Patient Name	DOB

Fill out a page for each child.

All Children Pediatrics HEALTH QUESTIONNAIRE
INSTRUCTIONS: Please **print or write legibly**. Fill additional sheets out for each child. **Only one (1)** SOCIAL AND FAMILY History form needs to be completed. Comment on specifics.

MEDICATIONS: List all current medications and strengths your child is on:

_____
_____
_____

ALLERGIES:
☐ Drug Allergies: List all _____

☐ Allergic Rhinitis ☐ Asthma ☐ Urticaria (hives)
☐ Eczema / chronic dry skin ☐ Food intolerance

NEWBORN PERIOD:
☐ Vaginal delivery ☐ C-Section ☐ Difficult Delivery
☐ Term ☐ Premature ☐ Birth weight _____
☐ Jaundice? ☐ Phototherapy? ☐ Heart or lung problems
☐ Feeding problems ☐ Delayed discharge home from nursery
☐ Other _____

FEEDING AND DIGESTION:
☐ Breast fed ☐ Bottle fed ☐ Appetite poor
☐ Vomiting ☐ Chronic loose stools ☐ Constipation issues
☐ Other_____

INFECTIONS, DEVELOPMENT, MISCELLANEOUS PROBLEMS:
☐ Dental problems ☐ Developmental delays ☐ Eye problems (glasses, etc)
☐ Frequent sore throats ☐ Frequent ear infections ☐ Hearing loss
☐ Heart problems ☐ Elevated blood pressure ☐ Seizures
☐ Pneumonia ☐ Pica (eating dirt, plants, etc.) ☐ Orthopedic problems
☐ Kidney or bladder infections ☐ Bed wetting ☐
☐ Other _____

SURGICAL PROCEDURES and HOSPITALIZATIONS
☐ Tonsillectomy, adenoidectomy and/or ear tubes ☐ Other surgical procedures
☐ Serious injuries (concussions, broken bones, etc)
☐ Hospitalizations: _____

PSYCHOLOGICAL PROBLEMS
☐ Antisocial behavior ☐ ADHD issues ☐ Drug use/abuse
☐ Discipline problems ☐ Breath holding ☐ School adjustment problems
☐ Peer relationships ☐ Tics/ nervous habits ☐ Learning disability
☐ Mental retardation ☐ Nightmares ☐ Temper tantrums
☐ Speech problems ☐ Poor school performance ☐ Anxiety
☐ Other: _____

PEDIATRICS HEALTH QUESTIONNAIRE

Mother and Age	Father and Age

Email address: _____

INSTRUCTIONS: Please **print or write legibly**. Fill additional sheets out for each child. **Only one (1)** SOCIAL AND FAMILY History form needs to be completed. Comment on specifics.

List all Children and DOB (Date of Birth)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

FAMILY SOCIAL HISTORY (SH)

Parent's marital status:
☐ Single ☐ Married ☐ Divorced and who has custody? _____

What are your living arrangements?
☐ House (Age? _____) ☐ Apartment
☐ Rent ☐ Own

How many adults live in the household? _____ How many children live in the household? _____

Parents Employed? Mother? Y N By Whom? _____
Father? Y N By Whom? _____

FAMILY HISTORY: "M" indicates Maternal (Mother's) side, "F" indicates Paternal (Father") side:

M	F	Disease	M	F	Disease
☐	☐	Unknown / No Information	☐	☐	Heart disease
☐	☐	No inheritable medical problems	☐	☐	Heartburn (GERD)
☐	☐	Alcoholism / drug use	☐	☐	High cholesterol
☐	☐	Allergies	☐	☐	High blood pressure
☐	☐	Asthma	☐	☐	Hyperthyroid (over-active thyroid)
☐	☐	Bleeding disorders	☐	☐	Hypothyroid (under-active thyroid)
☐	☐	Cancer	☐	☐	Iron deficiency / anemia
☐	☐	Cerebrovascular disease (stroke)	☐	☐	Kidney disease
☐	☐	Crohn's disease	☐	☐	Lupus
☐	☐	Depression	☐	☐	Mental illness(other than depression)
☐	☐	Diabetes	☐	☐	Rheumatoid arthritis
☐	☐	Eczema	☐	☐	Seizures
☐	☐	Early heart attacks (< age 50)	☐	☐	Tuberculosis
☐	☐	Hearing loss	☐	☐	Ulcerative colitis

List any other inherited health issues or serious health problems present in either side of the family not covered on the list above:

_____

_____