Pediatric Patient Questionnaire

Pregnancy & Birth:

Mother's Age at pregnancy:_____
Any illness during pregnancy:_____
Medications during pregnancy:_____
Smoking/Alcohol/Street Drugs during Pregnancy:_____
Weeks Gestation:_____Time of Delivery:_____
Type Delivery?_____Birth weight?_____Birth length?_____
Complications?_____Apgar?_____
Hospital where baby was born?_____
Problems soon after?_____ Did the baby spend any day in the NICU?_____
For Newborns Only: Did your baby receive the 1st Hepatitis B vaccine in the Hospital?_____
If so, please provide a copy of the immunization record from the hospital. Date of Hep B vaccine:_____

Feeding & Nutrition:

Appetite usually good?_____
Colic or feeding problems during the first 3 months?_____
Breastfed?_____Number of months?_____
Formula?_____Type:_____--
Vitamins?_____ Special Diet:_____

Past Medical History:

Is the patient on any medication:_____
Immunizations up to date:_____Do you have a record?_____
Hospitalizations: When and Where?_____
Past Allergic Reactions To:
Medications: YES or NO Animals: YES or NO Food: YES or NO Environmental: YES or NO
List Allergies and Type of Reaction:_____

Family Profile:

Parents Martial Status:_____
Mother's Age:_____Education:_____Health:_____
Father's Age:_____Education:_____Health:_____
List Child's brother, sisters & their ages: