

ALL CHILDREN PEDIATRICS

Patient Name	DOB
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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 _____

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergic Rhinitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Urticaria (hives) |
| <input type="checkbox"/> Eczema / chronic dry skin | <input type="checkbox"/> Food intolerance | |

NEWBORN PERIOD:

- | | | |
|---|--|--|
| <input type="checkbox"/> Vaginal delivery | <input type="checkbox"/> C-Section | <input type="checkbox"/> Difficult Delivery |
| <input type="checkbox"/> Term | <input type="checkbox"/> Premature | <input type="checkbox"/> Birth weight _____ |
| <input type="checkbox"/> Jaundice? | <input type="checkbox"/> Phototherapy? | <input type="checkbox"/> Heart or lung problems |
| <input type="checkbox"/> Feeding problems | | <input type="checkbox"/> Delayed discharge home from nursery |
| <input type="checkbox"/> Other _____ | | |

FEEDING AND DIGESTION:

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> Breast fed | <input type="checkbox"/> Bottle fed | <input type="checkbox"/> Appetite poor |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Chronic loose stools | <input type="checkbox"/> Constipation issues |
| <input type="checkbox"/> Other _____ | | |

INFECTIONS, DEVELOPMENT, MISCELLANEOUS PROBLEMS:

- | | | |
|---|---|--|
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Developmental delays | <input type="checkbox"/> Eye problems (glasses, etc) |
| <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Elevated blood pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pica (eating dirt, plants, etc.) | <input type="checkbox"/> Orthopedic problems |
| <input type="checkbox"/> Kidney or bladder infections | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> |
| <input type="checkbox"/> Other _____ | | |

SURGICAL PROCEDURES and HOSPITALIZATIONS

- | | |
|--|--|
| <input type="checkbox"/> Tonsillectomy, adenoidectomy and/or ear tubes | <input type="checkbox"/> Other surgical procedures |
| <input type="checkbox"/> Serious injuries (concussions, broken bones, etc) | |
| <input type="checkbox"/> Hospitalizations: _____ | |

PSYCHOLOGICAL PROBLEMS

- | | | |
|--|--|---|
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> ADHD issues | <input type="checkbox"/> Drug use/abuse |
| <input type="checkbox"/> Discipline problems | <input type="checkbox"/> Breath holding | <input type="checkbox"/> School adjustment problems |
| <input type="checkbox"/> Peer relationships | <input type="checkbox"/> Tics/ nervous habits | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Temper tantrums |
| <input type="checkbox"/> Speech problems | <input type="checkbox"/> Poor school performance | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Other: _____ | | |