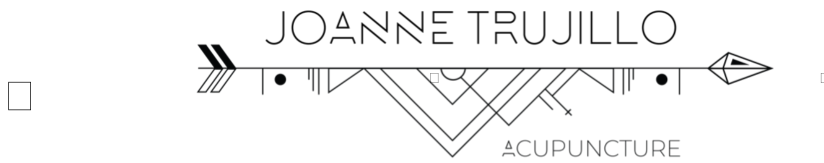

Pediatric Health History Questionnaire Age 0 to 12

Date: ____/____/____ Parents Names: ____

Child's Name: ______________________________ Age ____________

Address: ____Email address_______________________

City, State, Postal Code: ____

Home Phone: (______)________________________ Work Phone: (______)_________________________

Who does the child live with? □Mother □Father □Siblings # ______ □Step-parent □Step-siblings # ______

□Grandmother □Grandfather □Aunt □Uncle □Shared Custody

Is the child in: □Homecare □Daycare □Pre-school □School □Home Schooled

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Prenatal Information

What was the father's age at childbirth ______________ What was the mother's age at childbirth ______________

Adopted □yes □no Did the mother receive prenatal care? □yes □no □unknown

Did the mother use any of the following during pregnancy?

□Tobacco (first & second hand) □Alcohol □Recreational drugs □Supplements

□Prescription medications □Over the counter medications □unknown

If yes please list ____

Did the mother experience any of the following during pregnancy?

□Hypertension □Diabetes □Bleeding □Trauma □Stress □Eclampsia □Thyroid problems

□Pre-eclampsia □Chickenpox □Toxoplasmosis □Placenta Previa □Severe Vomiting

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Delivery Information:

□Premature □Over-due, number of days____________ Length of labor: __________ Weight at birth: __________

Delivered by: □Midwife □Home □Doctor □Hospital

Was the birth: □Induced □Vaginal □C-Section □Forceps □Suction

Anesthesia □yes □no

Other: (please describe) ____

Complications: ____

Developmental Milestones:

At what age did your child first;

Sit up _______ Crawl_______ Walk______ Talk_______ Attend Day Care_____ Use a Cup _____ Feed Self _____

Growth percentile at last check up_______ Date of last check up_______________

Was your child breast-fed □yes □no how long_________ bottle-fed □yes □no how long_________

Name or types of formulas used____

Does your child still get a bottle? □yes □no

At what age were solid foods introduced? _________

What foods were introduced before 6 months (Please list approximate month as well) _________________________

____

What foods were introduced between 6 and 12 months (Please list approximate month as well) ________________

____

____

Please list your child's food allergies / intolerances____

Are meals: □Regular □Irregular □Fed on demand □Grazing

Does your child sleep through the night? □yes □no number of wake ups per night □1 □2 □3 □more

Does your child wake for diaper changes? □yes □no □urine □stool, # of times per night □1 □2 □3 □more

Does your child wake for nighttime feedings □yes □no

Does your child wake with: □Dreams □Nightmares □Night terrors

Does your child fall asleep easily? □yes □no

What is your child's bedtime? __________ What time does your child rise in the morning? ________

How many hours does your child sleep at night?_________

How many naps per day? _____how long are the naps □15 min □30 min □1 hour □1:30 □2:00 □Longer

Any changes to bowel movements or stool consistency? □yes □no How long ago?_________

Frequency of daily bowel movements □0 □1 □2 □3 □4 □more often

Hard to pass □yes □no with crying □yes □no

Is stool consistency: □Hard and formed □Soft and formed □Soft and runny, no form □Explosive

□Foul smelling □Normal poop smell □Little or no smell □Undigested food in stool

Health history:

Check any that your child has or has had in the past:

□Acne
□Appendicitis
□Birth Defects
□Cardiovascular problems
□Chronic Cough
□Conjunctivitis
□Croup
□Diaper rash
□Ear ache
□Epilepsy
□Headaches
□Hyperactivity
□Jaundice
□Pain
□Scabies
□Sinusitis
□Tooth Loss (premature)
□Vomiting
□ADHD/ ADD
□Asthma
□Broken Bones
□Cerebral Palsy
□Chronic Colds
□Constipation
□Cystic Fibrosis
□Diarrhea
□Ear infections
□Fecal incontinence
□Heart murmur
□Impetigo
□ Learning disorder
□Paralysis
□Seizures
□Spina bifida
□Trauma
□Wheezing
□Allergies
□Bedwetting
□Bronchitis
□Chronic Abdominal pain
□Chronic Diarrhea
□Cradle cap (seborrheic dermatitis)
□Depression
□Dizzy Spells
□Eczema
□Frequent infections
□High fever
□Insomnia
□Moodiness
□Pneumonia
□Short stature
□Stuffy nose
□Urinary incontinence
□Yeast infection

Please explain ____

____

Developmental or physical concerns, in order of significance to you

1______________________________ 2____________________________________

3_____________________________ 4____________________________________

5_____________________________ 6___________________________________

List any Western medical diagnoses____

____

Does your child have a special attachment to any item □yes □no

What is it? ___________________________________ Please bring it in if appropriate.