Pediatric –Patient Questionnaire

Patient's Name: _____

Previous medical care- Dr. _____ Dental Care: Yes / No Eye Exam: Yes / No

Pregnacy & Birth (if child <2 years old)

Mother's age at pregnancy? _____

Any illness during pregnancy? Yes/ No _____

Medication during pregnancy? (Exclude vitamins and iron) Yes/ No _____

Smoking- Alcohol – Street drugs- during pregnancy? _____

Was baby early- on time – late? _____

Type of delivery? _____ Birth Weight _____ Length _____

Complications? Yes/ No _____ Apgar _____

Problems with baby at birth? Breathing: Yes/ No Jaundice: Yes/ No Other: _____

Problems soon after? _____ Nursery or home? _____

Past Medical History

Allergic reactions? Medicine: Yes / No Food: Yes/ No Animals: Yes / No Insect Bites: Yes / No

Medication taken on a regular basis? (Exclude Vitamins) _____

Immunizations – up to date? Yes / No Do you have a record? Yes / No

Hospitalizations- (when- where- why)? _____

_____

Serious Injures (when- where)? _____

Chicken pox	Yes / No	Asthma/ Wheezing	Yes / No	Anemia	Yes / No
Bleeding Tendency	Yes / No	Blood Transfusion	Yes / No	Seizures	Yes / No
Urinary Infection	Yes / No	Eczema/Hives	Yes / No	Ear infections	Yes / No
Problems Hearing	Yes / No	Vision Problems	Yes / No	Other _____	