Joy Peskin, M.D.

PEDIATRIC HEALTH QUESTIONNAIRE

Date ____________________

PLEASE PRINT

Child's Name: ____________________

Date of Birth: ____________________

Address: ____________________

____

Phone: ____________________

Referred by: ____________________

The purpose of this questionnaire is to gather important medical and social information about your child which will help us provide the best possible care. All information is of course confidential. Please answer as completely as you can.

FAMILY HISTORY. (Please include any deceased members of immediate family.)

(Give first and last names)	Age	D.O.B.	Major health problems & illnesses
Child's father			
Child's mother			
1. Child's brothers, sisters			
2.			
3.			
4.			
5.			

Father's occupation ____________________ Mother's occupation ____________________

Does mother live in same residence with child? ☐ Yes ☐ No

Does father live in same residence with child? ☐ Yes ☐ No

Does anyone living in the home/sitter smoke? ☐ Yes ☐ No

Is child regularly in nursery school? ☐ Yes ☐ No

Is child regularly with babysitter? ☐ Yes ☐ No

Other people living with family? ____________________

Has the child or any other family members had any of the following conditions? (If yes, please state who.)

Diabetes	Mental retardation	Smoking history
Asthma	Birth deformity	Drug problem
Allergies/hay fever	Leukemia	Mental illness
Tuberculosis	Cancer	Any others:
Kidney trouble	Epilepsy (convulsions)	a.)
Arthritis	Heart disease	b.)
High blood pressure	Drinking problem	c.)

PREGNANCY AND BIRTH HISTORY

Name **and location** of obstetrician or other provider during pregnancy ____________________

____________________ Mother's age during pregnancy ____________________

Did mother have problems during pregnancy with any of the following? If so, please check:

Yes	No		Yes	No	
☐	☐	Infections:	☐	☐	Diabetes:
☐	☐	Bleeding:	☐	☐	Sugar in urine:
☐	☐	High blood pressure:	☐	☐	Protein in urine:
☐	☐	Rashes:	☐	☐	Others:
☐	☐	Severe vomiting:	☐	☐	

Did mother take any medications during pregnancy besides vitamins and iron? ☐ Yes ☐ No

If yes, please state which: ____________________

Were there any of the following complications of labor? If so, please check:

Yes	No		Yes	No	
☐	☐	Breech	☐	☐	C-section - Why?
☐	☐	Induced labor - Why?	☐	☐	Any other?

Baby was born: On time ________

Late ________ How late? ____________ weeks

Early ________ How early? ____________ weeks

Baby's birth weight ____________

SEE OTHER SIDE

Did baby have any problems in the delivery room or in the nursery?

Yes	No	
☐	☐	Difficulty breathing
☐	☐	Needed oxygen
☐	☐	Jaundice
☐	☐	Infections
☐	☐	Feeding problems
☐	☐	Other ______

Did baby go home with mother? ☐ Yes ☐ No

MEDICAL HISTORY: Child's general state of health. Good ☐ Fair ☐ Poor ☐

Hospital admissions, operations - please list below:

Hospital	Date	Reason

Please list any serious accidents or broken bones: ______

IMMUNIZATIONS:

Type	Dates	Type	Dates	Type	Dates
DPT		Oral Polio		Influenza	
DT / dT		Measles		MMR	
Tetanus		HIB		Other	

TB (Tine, PPD) ______

Do you feel that your child is developing normally in comparison to other children? ☐ Yes ☐ No

If not, state problem areas. ______

Has your child any serious or persistent problems with any of the following? If yes, please check and state specific problem:

Yes	No	
☐	☐	Skin
☐	☐	Eyes or vision
☐	☐	Speech
☐	☐	Teeth
☐	☐	Feeding
☐	☐	Learning problems
☐	☐	Ears or hearing
☐	☐	Behavior (home or school)
☐	☐	Urinary infections
☐	☐	Bed-wetting
☐	☐	Bowel problems
☐	☐	Overweight
☐	☐	

Yes	No	
☐	☐	Has the child had any bad reactions to medications? If so, which ones? ______
☐	☐	Does your child take any medications or treatments regularly? If so, state which: ______

I represent each and all of the foregoing answers to be true and complete.

Parent or Guardian Signature ______ ***Date*** ______

Physician Signature ______ ***MD*** ***Date*** ______