ADULT & PEDIATRIC PHYSICIANS GROUP – ALLEN & FRISCO
PHONE: (972) 359-0000 FAX: (972) 359-1000 E-MAIL: MAIL@CLINIC2000.COM

PEDIATRIC PATIENT QUESTIONNAIRE

LAST NAME: ***FIRST NAME:*** ***DATE OF BIRTH:***

Please check [Y] **yes or** [N] **no, circle or explain where required. N/A-Not Applicable**

Reason for today's visit -

Previous medical care - Dr. **Dental Care** [Y] [N] **Eye Exam** [Y] [N]

PREGNANCY & BIRTH

Mother's age at pregnancy? _____

Any illness during pregnancy? [Y] [N] _____

Medications during pregnancy? [Y] [N] _____

(exclude vitamins & iron) _____

Smoking - alcohol - street drugs - during pregnancy? _____

Was baby early - late - on time? _____

Type of delivery? _____ **Birth weight** _____ **Length** _____

Complications? [Y] [N] _____ **Apgar** _____

Problems with baby at birth? Breathing [Y] [N] **Jaundice** [Y] [N]

Other _____

Problems soon after? Nursery or home? _____

PAST MEDICAL HISTORY

Allergic reactions? Medicine [Y] [N] **Food** [Y] [N] **Animals** [Y] [N]

Insect bites [Y] [N] _____

Medications taken on a regular basis? (exclude vitamins) _____

Immunizations - up to date? [Y] [N] **Do you have a record?** [Y] [N]

Hospitalizations - (when-where-why?) _____

Serious injuries (when-where?) _____

Red Measles	[Y] [N]	**Mumps**	[Y] [N]	**German Measles (3 day)**	[Y] [N]
Chicken Pox	[Y] [N]	**Whooping Cough**	[Y] [N]	**Rheumatic Fever**	[Y] [N]
Scarlet Fever	[Y] [N]	**Ear Infections**	[Y] [N]	**Strep Throat**	[Y] [N]
Asthma/Wheezing	[Y] [N]	**Eczema/Hives**	[Y] [N]	**Seizures**	[Y] [N]
Anemia	[Y] [N]	**Hepatitis**	[Y] [N]	**Problems with hearing**	[Y] [N]
Bleeding Tendency	[Y] [N]	**Urinary Infections**	[Y] [N]	**vision**	[Y] [N]
Blood Transfusions	[Y] [N]	**Joint Problems**	[Y] [N]	**Other**	

FEEDING & NUTRITION

Food Allergies

Appetite usually good? [Y] [N]

Colic or feeding problems during the first 3 months? [Y] [N]

Breast fed? [Y] [N] **Number of months?** [Y] [N]

Formula? [Y] [N] **Current brand?** _____

Vitamins? [Y] [N] **Brand?** _____ **Fluoride?** [Y] [N]

Special Diet? [Y] [N] _____

FAMILY PROFILE

Parents - Married? ☐ **Separated?** ☐ **Divorced?** ☐

Father's age? _____ **Highest school grade?** _____ **Health?** _____

Mother's age? _____ **Highest school grade?** _____ **Health?** _____

(List child's brothers, sisters & their ages)

_____

_____

_____

FAMILY MEDICAL HISTORY

List all blood relatives of your child who have had the following problems - use abbrev. (F) Father, (M) Mother, (B) Brother, (S) sister, (MM) Mother's Mother, (MF) Mother father, (FM) Father's Mother, (FF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin

Anemia/Blood Dis _____
Asthma _____
Mental Retardation _____
Drug Problem _____
Alcoholism _____
Cancer _____
Aids _____
Cystic Fibrosis _____
Musc. Dystrophy _____
Tuberculosis _____
Arthritis _____
Epilepsy / Seizures _____
Heart Disease _____
High Blood Pressure _____
Cholesterol Problem _____
Migraine _____
Sudden Infant Death _____
Birth Defects _____
Early Deafness _____
Diabetes _____

DEVELOPMENT AND BEHAVIOR

Age at which child -

Sat alone ____ **Walked** ____ **Used sentences** _____
Toilet trained _____ **Bicycled** _____
Development compared to other children? _____

Grade in school ____ **Problems in School?** [Y] [N]

Learning problems? [Y] [N] _____
Getting along with other children? [Y] [N] _____
Behavior problems? [Y] [N] _____
Bad habits? _____ **Bedwetting?** [Y] [N]
Nail biting? [Y] [N] **Sleeping?** [Y] [N] **Hobbies - sports -**
Use of street or illegal drugs? [Y] [N] _____

SYNOPSIS