DELAWARE VALLEY PEDIATRIC ASSOCIATES • MEDICAL HISTORY QUESTIONNAIRE

Child's Name _____ **Date of birth** _____ **Today's Date** _____

PARENTS

Mother's Name _____ Age _____
Occupation _____
Father's Name _____ Age _____
Occupation _____
If parents work outside the home, what are the childcare arrangements?

_____
Is the child in nursery school or preschool? [ ] YES [ ] NO

PREGNANCY & BIRTH

Mother's age at birth _____
Did mother have any illness during pregnancy? [ ] YES [ ] NO
• If so, what? _____
Did mother take any medications other than vitamins? [ ] YES [ ] NO
• If so, what? _____
Was baby premature? [ ]YES [ ]NO If so, how many weeks? _____
Birth weight _____ Length _____
APGAR score _____
Did baby have any problem starting to breathe? [ ] YES [ ] NO
Did baby have any problems while in hospital? [ ] YES [ ] NO
• If so, what? _____
Treatments? _____

PAST MEDICAL HISTORY

Date of last checkup? _____
Date of last dental checkup? _____
Has your child had any allergic reactions to medications, insect bites, or food?
[ ]YES [ ]NO If so, what? _____

_____
Does your child have any other allergies? [ ] YES [ ] NO
• If so, what? _____
Has your child had any reactions to immunizations? [ ] YES [ ] NO
• If so, to which ones? _____
Any hospitalizations other than birth? [ ] YES [ ] NO
• If so, when and for what? _____

_____
Any serious injuries? [ ] YES [ ] NO
• If so, what? _____

FAMILY HISTORY

Is mother in good health? [ ] YES [ ] NO
• If no, state problem: _____
Is father in good health? [ ] YES [ ] NO
• If no, state problem: _____
Other children (if any):

Name	**Age**	**Health Problems**

Circle any of the following for which there is a family history: anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, mental illness, drug problems, alcohol problems, thyroid, cancer, obesity, learning problems, ear disease.
Have any of your children died? [ ] YES [ ] NO

_____

FEEDING AND NUTRITION

Is your child's appetite usually good? [ ] YES [ ] NO
Is it good now? [ ] YES [ ] NO
Was/is the baby breastfed? [ ] YES [ ] NO
If yes, for how long? _____

FEEDING AND NUTRITION, CONT'D.

If bottle fed, which formula? _____
Age of introduction to solid food? _____
Severe colic or feeding problems? [ ]YES [ ]NO
• If yes, what? _____
Does your child take vitamins? [ ]YES [ ]NO
• If yes, what type? _____
Any food intolerance? [ ]YES [ ]NO
• If yes, which foods? _____

REVIEW OF SYSTEMS

Does your child suffer from any of the following: [ ]YES [ ]NO
• Frequent ear infection [ ]YES [ ]NO
• Eye problems [ ]YES [ ]NO
• Teeth problems [ ]YES [ ]NO
• Frequent colds or sore throats [ ]YES [ ]NO
• Asthma, pneumonia, or recurrent cough [ ]YES [ ]NO
• Heart condition or disease [ ]YES [ ]NO
• Urinary or bladder infections [ ]YES [ ]NO
• Diarrhea, constipation or bowel problems [ ]YES [ ]NO
• Convulsions or nervous system problems [ ]YES [ ]NO
• Eczema, hives, or other skin conditions [ ]YES [ ]NO
• Anemia (now or in the past) [ ]YES [ ]NO
• Hearing problems [ ]YES [ ]NO
• Speech problems [ ]YES [ ]NO
List any other medical problems: _____

_____
For teenage girls:
• Age beginning breast development: _____
• Age first menses: _____
• Are menses regular? _____

DEVELOPMENT/BEHAVIOR

At what age did your child: Sit alone: _____ Walk alone: _____
Make short sentences (2-3 words): _____
Did your child say any words by 18 months of age? [ ]YES [ ]NO
Does your child have any trouble sleeping? [ ]YES [ ]NO
What school does your child attend? _____
What grade is he/she in? _____
Does your child have any trouble in school? [ ]YES [ ]NO
Any problems with reading or math? [ ]YES [ ]NO
Does your child get alone well with other children? [ ]YES [ ]NO

Circle any of the following with which your child has problems: nail biting, thumb sucking, bed wetting, toilet training, nightmares, night terrors, bad temper, hyperactivity, trouble concentrating, disciplinary issues, destructive behavior.
Other: _____

SAFETY/ENVIRONMENT

Do you live in a private house, apartment or mobile home? (circle one)
What type of heating do you have? _____
Temp of your home's water heater? _____
Are there smoke alarms in your house? [ ]YES [ ]NO
Does your child always wear a car seat/belt in the car? [ ]YES [ ]NO
Are there any smokers in the house? [ ]YES [ ]NO
How old is your house or apartment? [ ]YES [ ]NO
Any problems with the condition of your house? [ ]YES [ ]NO
Any pets? [ ]YES [ ]NO If yes, what type: _____

_____
Does your child wear a helmet when riding a bicycle? [ ]YES [ ]NO
Has your child been checked for lead: [ ]YES [ ]NO
Does your child smoke? [ ]YES [ ]NO