

Comprehensive Patient History Questionnaire
(Answer only those questions that pertain to your child's age group)

Patient name: _____ Age: _____ Today's date: _____
Mother's name: _____ Age: _____ Occupation _____
Father's name: _____ Age: _____ Occupation _____

This form is completed by: natural mother natural father patient other _____

What daycare arrangements do you have for your child? _____

A. Pregnancy and Birth (Fill out is your child is 24 months or less)

1. Mother's age at birth of child _____
2. Did mother have any illness during pregnancy? NO YES
3. Did she take any medications other the vitamins and iron? NO YES
4. Was the baby on time? YES NO
 - a. If no, how many weeks early or late? _____
5. Baby's birth weight? _____
6. Did the baby have trouble starting to breathe? NO YES
7. Did the baby have any trouble while in the hospital? NO YES
 - a. If yes, what kind? _____

B. Feeding and Nutrition(Fill out is your child is 24 months or less)

1. Is your child's appetite usually good? YES NO
2. Is it good NOW? YES NO
3. Was there severe colic or any unusual feeding issues during the first 3 months? NO YES
4. Do any foods "disagree" with your child? NO YES
5. For the first 6 months was your child fed by: BREAST BOTTLE
6. If on formula now, what kind? _____
7. Do you give your child vitamins? YES NO

C. Developmental/ Behavior (Fill out for school age children)

1. At what age did your child sit alone? _____
2. At what age did your child walk alone? _____
3. Did he/she say any words by the age of 18 months? YES NO
4. How does your child compare to others their age? _____
5. Does your child have any problems sleeping? NO YES
6. What grade is your child in school? _____
7. Has your child had any trouble in school? NO YES
8. Does your child get along with other children? YES NO
9. Check if your child has had any of the following:
___ Nail Biting ___ Thumb Sucking ___ Bed Wetting ___ Toilet Training Problems
___ Bad Temper ___ Hyperactivity ___ Speech Problems ___ Problems with Discipline

- D. Do you have a record of your child's immunizations? YES NO

Please turn paper over and continue on other side

E. Past Medical History (Fill out for ALL age children)

1. Where has your child gone for check ups until now? _____
2. Date of last check up _____
3. Date of last dental check up _____
4. Any allergic reactions to food, medication, insect bites? NO YES
a. If yes, which ones? _____
5. Has your child had any reactions to immunizations? NO YES
a. If yes, which ones? _____
6. Any hospitalizations other than birth? NO YES
a. If yes, for what? _____
7. Any serious injuries? NO YES
a. If yes, what kind? _____
8. Are any medications taken regularly? NO YES
a. If yes, which ones? _____

F. Family History(Fill out for ALL age children)

1. Are the child's natural parents both in good health? YES NO
2. Check any disease(s) that the child's parents, grandparents, siblings, aunts or uncles have had: ___ Anemia
___ Asthma ___ Allergies ___ Diabetes ___ High Blood Pressure ___ Obesity
___ Heart Issues ___ TB ___ Mental Illness ___ Drug Addiction ___ Cancer
___ Inherited Illness ___ Venereal Disease ___ AIDS ___ Other _____
3. List age, sex, and general health of all siblings: _____
4. Are any of your children deceased? NO YES

G. Review of the Systems(Fill out for ALL age children)

1. Has your child had frequent ear infections? NO YES
2. Any eye problems? NO YES
3. Problems with teeth? NO YES
4. Does he/she have frequent colds? NO YES
5. Is there a recurrent cough or asthma? NO YES
6. Heart murmurs or any other heart problems? NO YES
7. Any problems with urination? NO YES
8. Any problems with diarrhea or constipations? NO YES
9. Any convulsions of other nervous system issues? NO YES
10. Any eczema, hives, or other skin conditions? NO YES
11. Has your child ever been anemic? NO YES
12. Any diabetes or thyroid problems? NO YES
13. Please list any additional medical problems _____

Additional comments or questions:

Signature of the person who completed form: _____ Date: _____

Reviewed by (medical staff, MD): _____ Date: _____