*"Your Family Clinic
Your Medical Home"*

Pediatric Health Questionnaire

Name: ______________________________ Date of birth: ______________ Sex: F ☐ M ☐

Mother's name ______________________ Father's Name: ________________________________

Primary Care Physician: ______________________ Name of school: ____________________________

Drug Allergies / Reactions:

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Current Medications:

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Birth History:

Birth weight: __________ Full-term: Yes ☐ No ☐ Pre-term: _____ Late: _____

Problems during pregnancy: __________________ During delivery:____________

Delivery: vaginal ☐ c-section☐

Vaccinations up to date: Yes ☐ No☐

Past Medical History:

Asthma	☐	Measles/Mumps	☐	Developmental delay	☐
Ear infections	☐	Sinus problems	☐	Speech Problems	☐
Pneumonia	☐	Breathing Difficulties	☐	Seizure disorder	☐
Kidney disease	☐	Heart problem/murmur	☐	Liver disease	☐
Thyroid	☐	Urinary infections	☐	Vision problems	☐
Bleeding disorder	☐	Diabetes	☐	Snoring	☐
Constipation	☐	Diarrhea	☐	Headache	☐
Allergies	☐	Skin problems / rashes	☐	Throat Infections	☐
Bronchitis	☐	Other _________________		Anemia	☐
Chicken pox	☐	Other _________________			

Hospitalizations:

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Surgeries:

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Family History:

High Blood pressure	☐	Mental illness	☐	Liver Disease	☐
Diabetes	☐	Birth Defects	☐	Developmental delay	☐
Thyroid	☐	Sickle Cell Disease	☐	Other:_____________	
Heart Attacks	☐	Asthma	☐	Other:_____________	
Strokes	☐	Alcohol Abuse	☐		
Heart Disease	☐	Drug Abuse	☐		
Cholesterol	☐	Bleeding disorders	☐		
Deafness	☐	Muscular disorders	☐		
Cancer	☐	Lung disease	☐		