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PEDIATRIC QUESTIONNAIRE

PATIENT'S NAME: _____ SEX ____ BIRTHDATE _____

NAME OF PERSON FILLING OUT FORM _____ RELATIONSHIP TO CHILD _____

PAST HISTORY

Mother's MAIDEN NAME: _____

BIRTH HISTORY [ ] TERM(37-42 wks)[ ] PREMATURE(less than 37 wks)[ ] POST TERM(more than 42 wks)

BIRTH WEIGHT _____ LENGTH OF STAY IN HOSPITAL _____ DAYS

COMPLICATIONS AT BIRTH OR FIRST TWO WEEKS OF LIFE _____

_____

HOSPITALIZATIONS [ ] NEVER [ ] 1-3 TIMES [ ] MORE THAN 3 TIMES

Please list the following information for the last three hospitalizations

	OPERATION OR ILLNESS	MONTH AND YEAR	HOSPITAL AND CITY
1.			
2.			
3.			

MEDICAL Please check if your child has had any of the following:

yes no		yes no		yes no	
[ ][ ]	MEASLES	[ ][ ]	ECZEMA OR SKIN RASHES	[ ][ ]	HEART MUMUR OR HEART DISEASE
[ ][ ]	MUMPS	[ ][ ]	HAY FEVER	[ ][ ]	ANEMIA OR LOW BLOOD
[ ][ ]	GERMAN MEASLES	[ ][ ]	HIVES	[ ][ ]	YELLOW JAUNDICE
[ ][ ]	CHICKEN POX	[ ][ ]	ASTHMA	[ ][ ]	BROKEN BONES
[ ][ ]	MONONUCLEOSIS	[ ][ ]	PNEUMONIA	[ ][ ]	CONCUSSION OR HEAD INJUI
[ ][ ]	EXPOSED TO TUBERCULOSIS	[ ][ ]	SCARLET FEVER	[ ][ ]	SEIZURES OR FITS
[ ][ ]	BLADDER OR KIDNEY INFECTION	[ ][ ]	RHEUMATIC FEVER	[ ][ ]	SEVERE BURNS

OTHER ILLNESS (please list) _____

MEDICATIONS

Please list all medications, non-prescription medicines and vitamins the child is now taking:

MEDICINE OR VITAMIN	DOSE(How Much)	FREQUENCY(How Often)

ALLEGERIES

Has the child had any allergy or reaction to any of the following:

[ ] PENICILLIN
[ ] ASPIRIN
[ ] TETANUS OR OTHER SHOTS
[ ] OTHER DRUG(Please specify) _____
[ ] ANY FOOD(Please specify) _____
[ ] OTHER(Please specify) _____