UR Health Medical Center, Inc.
Pediatric History Questionnaire

Date: ____

Child's Full Name______________________________________ M/F DOB:__________________ Age:______

Address:____

Home Phone: ____________________Cell Phone: _____________________Work Phone:_____________________

Pharmacy Name: ______________________________________Pharmacy Number:_________________________
How did you hear about us: ☐ Friend/Family ☐Social Media ☐ Mailing Other:_____________________

Household-Please (list all those living in the child's home)

Name	Relation to Child	Age	Health Problems

Pregnancy & Birth

Birth Weight: Weight_____ lbs___oz length____ Was the baby born at term?____Early?_____Late?______
If early how many weeks gestation? __________ Date of adoption (if applicable)_________________________
Delivery by: ☐Vaginal ☐ Caesarean If caesarean why?____

____
Did mother have any illness or problems with pregnancy? ☐ Yes ☐No Explain__________________________

____
During pregnancy did mother: Smoke☐ Yes☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications:☐ Yes ☐ No What and When?____
Did baby have any problems right after birth? ☐ Yes ☐ No Was initial feeding Brest ☐ Bottle ☐
Did baby go home with mother from the hospital ☐Yes ☐No Explain___________________________________

General (If applicable)

Do you consider your child to be in good health? ☐Yes☐No Explain_________________________
Does your child have any serious illness or medical condition ☐Yes☐No Explain________________________
Has your child had serious injuries or accidents ☐Yes☐No Explain_________________________
Has your child had any surgery? ☐Yes☐No Explain_________________________
Has your child been hospitalized? ☐Yes☐No Explain_________________________
Is your child allergic to any medicine or drugs? ☐Yes No Explain__________________________
Does your child take any medications on a regular basis ☐Yes☐No Explain_________________________

Development

At what age did your child: Sit alone_____ Walk alone_____ Say words______ Toilet Train(daytime)______

Dental History

Has child been seen by a dentist: ☐Yes ☐No If yes how often? ☐Yearly ☐twice a year☐ other___________
Date of last visit:____________.

Home Environment-please check all that are in the household where the child resides:

☐ Smokers ☐ Smoke Detectors ☐Pets (type)_________________________
☐ Guns/Firearms ☐ Carbon monoxide detectors
Was your house built before 1950☐ Yes ☐ No Is violence at home a concern? ☐Yes ☐No

Family History-have any family members had the following:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Dad	Dad's Mom
Allergies (food or environmental)								
Anemia/Bleeding disorder								
Asthma								
Autoimmune								
Bleeding Problems								
Cancer								
Congenital Anomaly or birth defect								
Depression								
Diabetes								
Heart Disease								
High Blood Pressure								
High Cholesterol								
Eczema								
Food Allergy								
Genetic Disorder								
Hearing Disorder								
High Cholesterol								
High Blood Pressure								
Immune Disorder								
Kidney Disease								
Learning Disability								
Mental Retardation								
Mental Illness								
Seasonal Allergies								
Sudden Unexplained Death								
Thyroid Disorder								
Epilepsy or convulsions								
Liver/Kidney disorders								
Gastrointestinal problems								

Past History if applicable)-Does your child have or has he/she ever had:

Condition	Yes	No	When
Chickenpox			
Frequent ear infections/hearing loss			
Problems with vision or eyes			
Asthma, bronchitis, bronchiolitis or pneumonia			
Any heart problem or heart murmur			
Anemia/bleeding problem			
Frequent abdominal pain/constipation			
Bladder or kidney infection			
Bed wetting (after 5 years old)			
(For Girls) has she started her menstrual period			
Chronic or recurrent skin problems			
Frequent headaches			
Convulsions or other neurological problems			
Diabetes			
Thyroid or other endocrine problems			
Alcohol/drug abuse			

REVIEW OF ORGAN SYSTEMS
PLEASE CIRCLE ANY SYMPTOMS YOUR CHILD IS EXPERIENCING
IF YOUR CHILD HAS MORE THAN ONE SYMPTOM ON A LINE (√) THE RELEVANT ONE(S)

Constitutional/Endocrine
Fevers/chills/excessive sweating
Nausea vomiting/diarrhea

GastrointestinalRespiratory,
Cough/wheeze
Unexplained weight loss/gain
Diarrhea
Constipation
Blood in stools

Neurological
Weakness
Clumsiness
Headaches

Genitourinary
Bedwetting nightmares
Pain with urination
discharge penis or vagina

Blood/Lymph
Unexplained lumps
Easy bruising/bleeding

Eyes
Squinting/crossed eyes
Asymmetric gaze

Allergy
Hay fever/itchy eyes

Muscular/skeletal
Muscle/joint pains

Skin
Rashes

Cardiovascular
Tires easily with exertion
Unusual birthmarks/moles

Psychiatric/emotional
Problems with sleep
Nightmares

Ear/Nose/Throat
Unusually loud voice/hard of hearing
Mouth breathing/snoring

Speech problems
Anxiety stress
Depression
Nail biting/thumb sucking
Bad temper/breath holding/jealousy

Bad breath
Frequent runny nose
Problems with teeth/gums

I hereby certify that the information given on this form is accurate and true to the best of my knowledge.

*Guardian Signature:*______________________________________ *Relation to patient*___________________