



**PEDIATRIC HEALTH
QUESTIONNAIRE**

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Stamp Patient Card Here

PLEASE FILL OUT AS COMPLETELY AS POSSIBLE

Name _____ Med. Record # / Birthdate / or SS# _____

Home Telephone _____ Work Telephone _____

Grade (if in School): _____ Contact Person for Child's Appointments _____

Referring Physician _____

Primary Care Physician	Name _____	Address (or City) _____	Telephone # _____
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	Name _____	Address (or City) _____	Telephone # _____
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Pharmacy	Name _____	Address (or City) _____	Telephone # _____
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	Name _____	Address (or City) _____	Telephone # _____
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REASON FOR VISIT: _____

List Your Medications

(include over the counter, creams & Topicals and naturopathic medications)

1. _____

2. _____

3. _____

4. _____

5. _____

What allergies do you have to Medications OR Foods?

1. _____

2. _____

3. _____

Allergies to Latrex? Yes _____ No _____

Allergy to Lidocaine: Yes _____ No _____

Describe or Other Comments:

Are you currently taking aspirin, Motrin, Advil, Coumadin or Vitamin E?

Yes _____ No _____ off _____ days

SOCIAL HISTORY:

Parent's Occupation: Father _____ Mother _____

Or Guardian _____

No. of Siblings in household: Brothers _____ Sisters _____

Child's Activities / Sports _____

Smokers in Household? Yes _____ No _____

Immunization up to date? Yes _____ No _____

Pets in Household? Type? _____



OC4501



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MEDICAL & FAMILY HISTORY:

Current or past problem with:

Any Comments?

Constitutional / Symptoms

(i.e. Weight loss) Yes _____ No _____

Eyes Yes _____ No _____

Ears, Nose & throat Yes _____ No _____

Respiratory (lungs) Yes _____ No _____

Gastrointestinal (GI) Yes _____ No _____

Genital / Urinary Yes _____ No _____

Muscle or bone problems? Yes _____ No _____

Arthritis Yes _____ No _____

Skin Yes _____ No _____

Birthmarks Yes _____ No _____

Diaper Rash Yes _____ No _____

Psoriasis Yes _____ No _____

Skin Cancer Yes _____ No _____

Scars (keloid / "thick") Yes _____ No _____

Nerve problems Yes _____ No _____

Endocrine (Diabetes, thyroid) Yes _____ No _____

Heart / Blood Vessels

Hypertension Yes _____ No _____

Congenital Heart Problems or Defects

Irregular Heartbeat Yes _____ No _____

Artificial Heart Valve	Yes	No	Antibiotics pre dental work?	Yes	No
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History Rheumatic Heart	Yes	No	Antibiotics pre dental work?	Yes	No
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Other:

Psychiatric Problems? Yes _____ No _____

Hematologic / Lymph Yes _____ No _____

Allergic / Immunologic:

Eczema / Atopic Derm. Yes _____ No _____

Hayfever Yes _____ No _____

Asthma Yes _____ No _____

Hepatitis / AIDS Yes _____ No _____

Immunosuppressed Yes _____ No _____

Transplant? Yes _____ No _____

Organ _____ **date** _____

MEDICAL EVENTS (FAMILY HISTORY) (Illness, operations, injuries & treatments, heredity diagnosis)

Please detail – include relationship to family member.

Patient Signature: _____ Date _____

Physician Signature: _____ Date _____