Please complete this questionnaire. It will be an important part of your child's medical record.

Patient Name: ____ Date: ____________________
DOB: ________________________ Age: _______________________

A. BIRTH HISTORY

Birth Weight: ____________ Full Term/Premature (circle one)

Pregnancy problems: ____

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Problems in the1st month of life: ____

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1. List any medical problems that your child has:

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2. Medications:

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3. List any hospitalizations that your child has had.

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4. List any surgeries/procedures that your child has had.

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5. Drug Allergies:

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6. Are Immunizations up to date? YES__________NO__________

B. Family History

1. Has anyone in the patient's family (or relative) had any of the following? If yes, check the box and list the person's relationship to the patient next to the problem.

- ☐ Cystic Fibrosis
- ☐ Sickle cell disease or trait
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart disease or stroke
- ☐ Anemia
- ☐ High cholesterol
- ☐ Constipation
- ☐ Cancer
- ☐ Pancreatitis
- ☐ Seizures
- ☐ Crohns disease/Colitis
- ☐ Asthma, Emphysema
- ☐ Liver problems
- ☐ Gall bladder problem

C. Social History:

1. Who lives in the same household the patient?

Name	Age	Relationship to patient	Any health problems

2. Grade in school: _________________

D. Review of Systems: Please check any of the following that are problems ***for your child:***

General
- ☐ None
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fevers/temperatures

Skin
- ☐ None
- ☐ Acne
- ☐ Easy bruising
- ☐ Skin rashes

Ears, Nose, Throat
- ☐ None
- ☐ Ear Infections
- ☐ Discharge from ears
- ☐ Nose bleeds
- ☐ Sinus problems
- ☐ Mouth Ulcers
- ☐ Trouble swallowing
- ☐ Hoarseness
- ☐ Sour taste in mouth
- ☐ Sore throat
- ☐ Dental problems
- ☐ Ear pain

Gastrointestinal (Stomach/Intestines)
- ☐ Constipation (hard or infrequent stools)
- ☐ Soiling underpants
- ☐ Diarrhea
- ☐ Vomiting./spitting up
- ☐ Heartburn
- ☐ Blood in stool
- ☐ Difficulty swallowing
- ☐ Stomach pain
- ☐ Nausea
- ☐ Liver problems/jaundice/hepatitis

Heart/Blood vessels
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Chest pain
- ☐ Palpitations (fast heart beat)
- ☐ Irregular heart beat
- ☐ Blood pressure problems

Genital/Urinary System
- ☐ Pain/burning with urination
- ☐ Blood in urine
- ☐ Increased frequency or amount of urine
- ☐ Swelling/retaining water
- ☐ Other urinary tract or kidney problems
- ☐ Menstrual problems
- ☐ Age at first menstrual period _______
- ☐ Date last menstrual period ended_____

Endocrine (Glands)
- ☐ Thyroid problems
- ☐ Poor growth
- ☐ Other hormone/gland problems

Neurologic (Brain/Nerves/Psychiatric
- ☐ Developmental delay
- ☐ Headaches
- ☐ Seizures
- ☐ Dizziness
- ☐ Fainting
- ☐ ADHD (hyperactivity)
- ☐ Decreased sensation
- ☐ Decreased muscle strength
- ☐ Change in behavior
- ☐ Other neurologic problems

Breathing/Lungs/Chest
- ☐ Coughing
- ☐ Wheezing
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Apnea (stops breathing)
- ☐ Pneumonia

Breasts
- ☐ Discharge from nipples
- ☐ Breast lumps/masses
- ☐ Other skin problems

Musculoskeletal
- ☐ Joint problems
- ☐ Weakness
- ☐ Scoliosis

Allergy/Immune System
- ☐ Allergies
- ☐ Immune problems
- ☐ Frequent infections
- ☐ Unusual infections

Eyes
- ☐ Wear glasses
- ☐ Blurry vision
- ☐ Double vision
- ☐ Eye pain

Hematologic (Blood problems)
- ☐ Bleeding disorders/easy bleeding
- ☐ Anemia
- ☐ Received blood transfusions
- ☐ Easy bruising
- ☐ Swollen lymph nodes
- ☐ Lumps/growths

E. Feeding History:

How was your child fed as an infant? ☐ Breast-fed ☐ Bottle-fed

What formula did (does) your child receive? ____

Is your child on a special or restricted diet? ☐ Yes ☐ No

If yes, please describe: ____

F. Stooling History:

Did your child pass meconium (stool) while in the nursery in the first 24-48 hours of life? ☐ Yes ☐ No

Did your child have normal stooling as a baby ☐ Yes ☐ No

Referring Physician:____ Phone number: (   )_______________________

Address: ____

Street City State Zip Code