ALAMO Family Practice

NEW PATIENT—PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

Name _____ Date of Birth_____

Mother's Name_____ Father's Name_____

Medical Illnesses

Diagnosis	Self	Family
Acid reflux		
ADD/ADHD		
Allergies		
Anemia		
Arthritis		
Asthma		
Birth defects		
Bleeding disorder		
Bone disorder		
Brain abnormality		
Cerebral palsy		
Cystic Fibrosis		
Diabetes		
Down's syndrome		
Hearing loss		
Heart disease		
High Blood Pressure		
High Cholesterol		
Kidney disease		
Learning disorder		
Liver disease		
Mental Illness		
Mental Retardation		
Muscle Disorder		
Physical Handicap		
Recurrent UTI		
Seizures		
Sickle cell anemia		
Skin disease		
Thyroid disease		
Tuberculosis		
Other:		

Surgeries

Surgery	Date
Appendix	
Adenoids	
Ear tubes	
Hernia	
Tonsils	
Vasectomy	
Other:	

Birth/Development History

Mother's age at patient's birth_____
Vaginal or C-section delivery_____
Full term Premature Late (circle one)
Does you child have or are you concerned about any developmental delay? Yes/ No
If yes, describe_____

Home Environment

Who does patient live with? (circle one)
Mother Father Both Parents Guardian(specify)_____
Does your home have smoke detectors? Y/N
Does your home have carbon monoxide detectors? Y/N
Which does your home have: city water(with fluoride) or well water
Ages and names of siblings _____
Type and number of pets_____
Are there any guns in the home? Y/N
If yes, are they locked away? Y/N

Allergies

Circle all that apply

Milk Egg
Peanut
Bee/wasp
Seafood
Penicillin
Other foods:
_____
_____
Other meds:
_____
_____

Medications

Please list all prescriptions and OTC/supplements you are currently taking, along with the dose and frequency

_____
_____

Preventive Health

Past doctor for checkups_____
Last dental checkup_____ Immunizations Up to Date ? Yes/ No
Does patient eat fruits/veggies? Y/N Does patient take vitamins? Y/N Does patient drink soda? Y/N
Does patient exercise? Yes/ No List any sports/hobbies_____
Does patient wear seatbelt at all times? Y/N Does patient ride in a car seat/booster seat? Y/N
Does patient wear bicycle helmet? Y/N Are there any smokers in the family? Y/N
Does patient: smoke? Y/N Drink alcohol? Y/N Use drugs? Y/N
Is patient sexually active? Y/N
For females, age at first menses? _____