Pinellas County Primary Care
AND HOSPITALISTS

Pediatric Health Information Questionnaire

Patient name: _____ Date: ___/___/___

Date of birth: _____ Age: _____ ❑ New patient ❑ Established patient

General Information

Who is completing this health form? _____

What is your relationship to the patient? _____

What is your preferred language for health care information? _____

What is the best way for the office to contact you? ❑ Phone ❑ Email ❑ Text ❑ Other

What is your preferred method of communication? ❑ Verbal ❑ Sign language ❑ Written ❑ Nonverbal ❑ Other

Interpreter required? ❑ Yes ❑ No

Does the patient have any disabilities or health limitations (e.g. blindness/hearing impairment)? ❑ Yes ❑ No

If yes, please list: _____

Allergies

Is the patient allergic to any medications? ❑ Yes ❑ No If yes, please list: _____

Medications

List all medications the patient takes on regular basis (include over-the-counter, herbal or natural remedies)

_____

_____

_____

Birth History

Pregnancy:

Medical problems? ❑ Yes ❑ No If yes, please list. _____

Hospital: _____

Pregnancy complications:

❑ None ❑ Gestational diabetes ❑ Fewer than three prenatal visits ❑ Multiple gestation

❑ Pregnancy induced hypertension ❑ Placental abruption ❑ Placenta previa ❑ Rh ❑ Sensitization

Maternal substance use during pregnancy:

❑ Smoking ❑ Alcohol use ❑ Medications ❑ Recreational drugs ❑ Other

Delivery:

❑ Normal ❑ Prolonged ❑ Difficult ❑ Vaginal ❑ C/Section ❑ Breech ❑ VBAC ❑ Other

Newborn:

❑ Full term ❑ Premature If premature, by how many weeks? _____

Date of birth _____ Time of birth _____ Birth weight _____

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Birth History

Newborn complications:

❑ Feeding problems ❑ Jaundice ❑ Breathing problems ❑ Fever ❑ Anemia

❑ Glucose problems ❑ Antibiotic therapy ❑ NICU admission ❑ Other ❑ Group B strep

Newborn leaving hospital:

Discharge date: ___/___/___ Discharge weight _____ Problems in nursery? ❑ Yes ❑ No

PKU before discharge? ❑ Yes ❑ No Date: ___/___/___ Time: _____

Feeding:

Formula? ❑ Yes ❑ No If yes, formula type? _____

Breast? ❑ Yes ❑ No If yes, how long? _____

Medical illnesses or conditions (list any chronic conditions the patient has been diagnosed with):

_____

_____

_____

Family History

Please indicate if the patient's blood relative(s) have had/currently have the following:

	Father	Mother	Grandparents	Aunt/Uncle	Siblings
Allergies					
Immunodeficiency					
Drug problems					
SIDS					
Birth defects					
Developmental delay					
Blindness					
Deafness					
Cystic fibrosis					
Muscular dystrophy					
Cancer					
Ulcer/heartburn					
Blood disease					

	Father	Mother	Grandparents	Aunt/Uncle	Siblings
Sickle cell disease					
Diabetes					
Hepatitis					
Tuberculosis					
Asthma					
High cholesterol					
Heart disease					
High blood pressure					
Kidney or bladder problems					
Seizures/convulsions					
Migraine					
Sudden death in family younger than age 55					

Pediatric Health Information Questionnaire

History/Hospitalizations/Medical Devices

Please list any surgery or procedure and the year it was performed:

_____

_____

Please list any hospitalizations and the year they occurred:

_____

_____

Has the patient ever had a transfusion? ❑ Yes ❑ No

If yes, did the patient have a reaction or problem with the transfusion? ❑ Yes ❑ No

Social History

Does the patient smoke? ❑ Yes ❑ No Does anyone smoke at home? ❑ Yes ❑ No

Does the patient drink alcohol? ❑ Yes ❑ No Is there alcohol abuse in your household? ❑ Yes ❑ No

Does the patient use drugs? ❑ Yes ❑ No Is there substance abuse in the patient's household? ❑ Yes ❑ No

Is the patient currently in school/daycare? ❑ Yes ❑ No If yes, what is the patient's grade level?_____

Does the patient have school concerns? ❑ Yes ❑ No

If yes, check the patient's concern. ❑ Learning ❑ Social ❑ Communication ❑ Health ❑ Cultural ❑ Other? _____

Does the patient regularly exercise? ❑ Yes ❑ No Times per week: ❑ 1 to 2 ❑ 3 to 4 ❑ 5 to 6 ❑ Daily

Tell us about the patient's nutrition/health:_____

_____

Does the patient eat a healthy diet? ❑ Yes ❑ No Is the patient on a special diet? ❑ Yes ❑ No

If yes, please explain _____

_____

What is the patient's appetite level? ❑ Good ❑ Fair ❑ Poor Does the patient take vitamins/supplements? ❑ Yes ❑ No

If yes, please list: _____

_____

Tell us about the patient's home environment.

❑ House ❑ Apartment ❑ Other ❑ Single parent

Who lives in the household with the child? ❑ Mother ❑ Father ❑ Siblings ❑ Others (Please list) _____

_____

Does the patient feel safe at home? ❑ Yes ❑ No If no, does the patient have a safe place to go? ❑ Yes ❑ No

Are there situations of injury/abuse/neglect in the patient's household? ❑ Yes ❑ No

Have agencies/others been notified? ❑ Yes ❑ No Does the patient have family/friends available to help? ❑ Yes ❑ No

Is there a concern for family members at home? ❑ Yes ❑ No Does the patient have any sleeping problems? ❑ Yes ❑ No

Does the patient use alternative healthcare? ❑ Yes ❑ No Is the patient sexually active? ❑ Yes ❑ No

Pediatric Health Information Questionnaire

Systems Review

Please indicate items that have been ongoing or a recent significant change.

Yes No

General

___ ___ Excessive colic
___ ___ Fatigue/lethargy
___ ___ Fever
___ ___ Unexplained weight loss

Eyes

___ ___ Drainage/discharge
___ ___ Glasses/contacts
___ ___ Redness or watering
___ ___ Stys
___ ___ Vision concerns
___ ___ Eye crossing

Ears

___ ___ Difficulty hearing
___ ___ Ear drainage
___ ___ Ear pain
___ ___ Frequent infections
___ ___ Hearing concerns

Nose/Sinuses

___ ___ Chronic runny nose
___ ___ Nose bleeds
___ ___ Nasal stuffiness
___ ___ Sinus trouble

Mouth/throat

___ ___ Dental defects
___ ___ Sore throat
___ ___ Large tonsils

Cardiovascular

___ ___ Murmur
___ ___ High cholesterol
___ ___ Chest pain
___ ___ Excessive fatigue with exercise

Psychiatric

___ ___ Attention problems
___ ___ Depression
___ ___ Moodiness
___ ___ Sleep disturbances

Yes No

Musculoskeletal

___ ___ Broken bones
___ ___ Hip problems
___ ___ Joint swelling
___ ___ Back pain
___ ___ Joint pain
___ ___ Muscle aches

Skin

___ ___ Dry skin
___ ___ Moles/birthmarks
___ ___ Pale skin color
___ ___ Recurrent rashes
___ ___ Jaundice
___ ___ Eczema

Respiratory

___ ___ Chronic cough
___ ___ Difficulty breathing
___ ___ Hoarseness
___ ___ Wheezing
___ ___ Apnea/breath holding
___ ___ Trouble breathing with exercise

Allergic/immunologic

___ ___ Frequent infection
___ ___ Recurrent hives
___ ___ Sneezing
___ ___ Hay fever

Gastrointestinal

___ ___ Abdominal pain
___ ___ Blood in stool
___ ___ Constipation
___ ___ Nausea/vomiting
___ ___ Vomiting blood
___ ___ Feeding difficulties

Genitourinary

___ ___ Abnormal discharge
___ ___ Blood in urine
___ ___ Pain urinating
___ ___ Burning
___ ___ Bed wetting/incontinence
___ ___ Frequent urination

Pediatric Health Information Questionnaire

Systems Review

Please indicate items that have been ongoing or a recent significant change.

Yes No

Blood/lymph

___ ___ Anemia
___ ___ Easy bruising
___ ___ Excessive bleeding
___ ___ Large lymph nodes

Neurological

___ ___ Seizures/convulsions
___ ___ Tremor
___ ___ Weakness/paralysis
___ ___ Limb paralysis
___ ___ Dizziness
___ ___ Fainting spells
___ ___ Migraine
___ ___ Frequent headaches

Endocrine

___ ___ Excessive eating
___ ___ Excessive drinking
___ ___ Cold intolerance
___ ___ Heat intolerance

Yes No

Reproductive (flex for by gender)

Female:

Date of last period: _____

___ ___ Vaginal discharge
___ ___ Vaginal itching/burning
___ ___ Irregular periods
___ ___ Painful periods
___ ___ Spotting between periods

Male:

___ ___ Swelling of the scrotal sac/testes
___ ___ Testicular pain
___ ___ Penile discharge

Comments: _____