Bambini Pediatrics PC

Wholesome Medical Care for Kids

Name: _____ Date of Birth: _____ MR# _____

Pediatric History Questionnaire

Family Member	Name	Birth Date	Healthy?
Father			
Mother			
Brothers			
Sisters			
Others living in household			

Are natural parents living together? _____ If not, please explain. _____

Growth & Development

Was pregnancy normal or difficult? If difficult, please explain. _____

Was delivery normal or difficult? If difficult, please explain. _____

Birth Weight: _____ Was the baby full term? ___ If not, how many weeks early? _____

Did your baby have any problems in the nursery? ____ If yes, please describe: _____

(Parents of newborns may skip down to family history)

At what age did child:

Walk without help?		Toilet trained?	
Talk (two words together)?		Stay dry at night?	

Hospitalizations, major illnesses, and Injuries

Age	Problem	Hospitalized?

Are there any problems that concern you about your child right now? _____

_____

_____

Any allergies to food or medication? ____ If yes, please list and explain reaction. _____

_____

List medications and dosages child is presently taking, including vitamins and supplements: _____

_____

Review of Symptoms: Indicate which of the following conditions or problems your child has *recently* had:

( ) Eye problems	( ) Acne	( ) Stomach pain
( ) Wears glasses	( ) Eczema	( ) Diarrhea
	( ) Rashes	( ) Constipation
( ) Frequent ear infections		
( ) Difficulty hearing	( ) Kidney/Bladder infection	( ) Headaches
( ) Frequent nose bleeds	( ) Bedwetting	( ) Seizures
( ) Frequent sore throats		( ) Learning difficulties
	( ) Painful periods	( ) Emotional problems
( ) Pneumonia	( ) Irregular periods	( ) Behavioral problems
( ) Asthma or bronchitis	( ) Sexually active	( ) Weight issues

Social History:

What does child do in spare time? _____

How much times does child spend watching TV, play video games, or use computer_____

How is he/she doing in school? _____

Does he/she have good friends? _____

Indicate any financial, interpersonal, or family problems you are worried about. _____

_____

Family History: Indicate conditions which close relatives (parents, siblings, & grandparents) have:

( ) High blood pressure	( ) Migraine	( ) Obesity
( ) Heart Attack/Stroke	( ) Epilepsy	( ) High Cholesterol
	( ) Mental Retardation	( ) Diabetes
( ) Eczema	( ) Psychiatric disorders	Other:
( ) Hay fever	( ) Alcoholism	
( ) Asthma	( ) Tuberculosis	

_____ _____

Date Completed Reviewed by: (MD, DO, NP, PA)