Pediatric and Family Physicians

PATIENT QUESTIONNAIRE / HISTORY

Form completed by ___________________________

Patient's Name _________________________

Relationship to Patient ________________________

Family History	Name	Birthdate	Health problems	At home	Occupation
	Father				
	Mother				
	Children				

Patients Birth history & Development

Birth date / Birth Wt. — Full term or Premature — Vaginal delivery / C section — Problems in nursery

Development: Normal for age — Concerns about development

Comments

Patients Past Medical History

Has your child had any of the following ? If so please circle

- Abdominal pain/ constipation/ vomiting
- Allergies / Asthma / Eczema
- Ear infections, recurrent
- Seizures
- Vision / Hearing problems
- School problems
- Emotional or psychological problems
- Any other not listed above

Comments

Hospitalizations Illness / Surgery (details)

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Family History

Do parents, grandparents or other children have any of the following? If so please circle

- Allergies / Asthma / Eczema
- Bleeding disorder
- Cancer
- Congenital anomalies
- Diabetes
- Depression/ Psychological problems
- Heart disease / Heart attacks
- Hypertension
- Kidney / Liver disease
- Migraine / Headaches
- Obesity
- Seizures / convulsions
- Sickle cell disease/trait
- Any other

comments

Do you have more than usual problems in managing your child ?

Do you have special concerns ?

Signature of Parent or Legal Guardian ______________________ **Date** ______________