Washington Township Medical Foundation
Part of Washington Hospital Healthcare System

Patient Name:_____

Date:_____

Pediatrics

Pediatric Health Questionnaire

A. Vital Data

1. Child's Birth Date:_____ ❑Boy or ❑Girl
2. Birthplace: Hospital_____ City_____

B. Pregnancy

3. Duration of pregnancy _____weeks
4. Were there any illnesses or complications, and if so, during what month of pregnancy?_____
_____

C. Delivery

5. Birth weight:_____ Length:_____
6. Any difficulties at the time of delivery?_____
7. In the nursery and the first 4 weeks, were there:

   Breathing problems?_____ Fever _____ Convulsions ?_____

   Was there yellow jaundice requiring treatment?_____

D. Family Background

8. Child lives with: ❑Both parents; ❑Mother only; ❑Father; ❑Other relative or guardian
9. Please **mark** if your child's blood relatives have ever had any of the following conditions.

Anemia (Sickle Cell, Mediterranean, etc.)_____ Bleeding disorders (Hemophilia)_____

Thyroid disease (Goiter, Nodule)_____ Diabetes_____

High blood pressure_____ Rheumatic fever or Rheumatic heart_____

Heart attack before age 55_____ Cystic Fibrosis_____

Allergies (Eczema, Hay fever, Hives)_____ Seizures (Epilepsy)_____

Alcoholism or drug abuse_____ Cancer or Leukemia_____

Sudden or unexplained death_____ SIDS_____

Other_____

E. Nutrition

10. ***During Infancy:*** Breast/bottle fed?_____, Duration :_____Months
11. Was the baby allergic or intolerant of any foods? ❑Yes or ❑No, if YES, which foods?_____
_____

12. ***During Childhood:*** Please describe diet_____
_____

Any dietary concerns _____
_____

During Adolescence: History of skipping meals/purging/restricting behavior? ❑Yes or ❑No, if YES Explain:_____
_____

F. Growth and Development

13. ***Development:*** Any history of developmental delay in your child? ❑Yes or ❑No, if YES, Describe:
_____

Growth: Any concerns about your child's growth or failure to thrive? ❑Yes or ❑No, if YES Describe:_____
_____

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G. Medical History

14. Indicate the age(s) at which your child might have had any of the following illnesses:

Mumps_____
Chickenpox_____
Whooping Cough_____
Rheumatic Fever_____
Asthma_____
Anemia_____
Convulsions_____
Heart Disease_____
Pneumonia_____
Hepatitis (Jaundice) _____
Regular (Red, Hard) Measles_____
Scarlet Fever_____
Kidney/Urinary disease_____
Rubella (German, 3-day) Measles_____
Constipation_____
Hearing loss_____
Vision Problems_____
Eczema_____

15. Has the child ever been seriously injured? ❑Yes or ❑No, Age:_____
16. Has the child had tonsils or adenoids removed? ❑Yes or ❑No, Age:_____
17. Has the child ever had a blood transfusion?_____
18. List other serious illnesses/hospitalizations/or surgeries (description & date)_____
_____
_____
19. Is your child regularly taking any medicine(s)? ❑Yes or ❑No, Which ones?_____
_____
_____
20. Is your child allergic to any medicines/foods, etc. ❑Yes or ❑No, if YES please list/circle below:

Medicines	**Foods**	**Type of reaction (rash, vomiting, diarrhea, etc.)**
Penicillin	Eggs	_____
Sulfa	Peanuts	_____
Others	Other	_____

H. Behavior

21. Are there behavior problems at home? ❑Yes or ❑No, if YES, please describe:_____
_____
_____
22. Is there any history of learning difficulties/disabilities or problems at school?❑Yes or ❑No, Describe:_____
_____
_____
23. Are there any concerns you would like to discuss with your child's doctor today? ❑Yes or ❑No, Describe:_____
_____
_____

Date:_____ Signature:_____