Heart of Texas Pediatrics

Name: _____ Date of Birth: _____
Medical Record #:_____

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 and 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 problems in the nursery? _____ If yes, please describe: _____

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

Social History:

What does child do in spare time? _____

How much time does child spend watching TV, playing video games, or using the 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
(__) Heart attack/ stroke
(__) Eczema
(__) Hay fever
(__) Asthma
(__) Migraine
(__) Epilepsy
(__) Mental retardation
(__) Psychiatric disorders
(__) Alcoholism
(__) Tuberculosis
(__) Obesity
(__) High cholesterol
(__) Diabetes
(__) Other:

Date completed: _____ Reviewed: _____