

SEA VIEW PEDIATRICS

CONFIDENTIAL HEALTH QUESTIONNAIRE

CHILD'S NAME	BIRTHDATE	TODAY'S DATE
NAME OF PERSON COMPLETING THIS FORM	RELATIONSHIP TO CHILD	

Please answer the following questions so we will be better able to help you assess and take care of your child's health. All answers will be confidential. Thank you.

1. Mother's Name _____ Birthdate _____ Living in home? Yes No
 Father's Name _____ Birthdate _____ Living in home? Yes No
 Guardian's Name _____ Birthdate _____ Living in home? Yes No

2. Is your child adopted? No Yes If yes, age at the time of adoption _____

3. Has your child had an allergic reaction to any drugs? No Yes If yes, what is (s)he allergic to?

4. Does your child have any other allergies (food, dust, pollen, bee or insect stings, feathers, etc.)?

5. Does your child have, or has (s)he had, any of the following?

- | | | |
|--|--|---|
| <input type="checkbox"/> Skin problems of long duration
<input type="checkbox"/> Eczema
<input type="checkbox"/> Hives
<input type="checkbox"/> Frequent fevers
<input type="checkbox"/> Eye problems / trouble seeing
<input type="checkbox"/> Many ear infections
<input type="checkbox"/> Hearing problems
<input type="checkbox"/> Speech problems
<input type="checkbox"/> Many colds
<input type="checkbox"/> Many sore throats
<input type="checkbox"/> Frequent coughing
<input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Bronchitis / Pneumonia
<input type="checkbox"/> Asthma
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Stomachaches / constipation / diarrhea
<input type="checkbox"/> Kidney / bladder problems
<input type="checkbox"/> Hernia
<input type="checkbox"/> Hip / leg / foot abnormalities
<input type="checkbox"/> Convulsions
<input type="checkbox"/> Bed wetting / soiling underpants / bedclothes | <input type="checkbox"/> Behavior problems
<input type="checkbox"/> Temper tantrums
<input type="checkbox"/> School problems
<input type="checkbox"/> Sleeping problems
<input type="checkbox"/> Eating pain
<input type="checkbox"/> Anemia
<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Serious injury
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> _____ |
|--|--|---|

6. Are there any other problems you would like to discuss? _____

7. What prescription and non-prescription medicines is your child currently taking regularly? (Be sure to include such medicines as vitamins, aspirin, iron, laxatives, etc.) _____

8. Was the pregnancy with this child: normal difficult? _____

9. Was the child born on time late early?

10. What was the child's birth weight? _____ lbs. _____ ozs.

11. What type of milk did the child have? breast feeding regular formula soy formula
 other _____

12. Did your child have any problems during the first months of life (colic, feeding problems, loose bowels, vomiting, jaundice, etc.)? No Yes _____

13. When did your child . . .

	On Time	Delayed	Not Yet
Smile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfer objects from one hand to the other.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk by him / herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talk (two words together)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feed him / herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Become bowel trained	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Become bladder trained	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. If your child is in school, how is (s)he doing? Well Average Poorly

15. If your child has been in the hospital for a medical or surgical reason, complete the following (use a separate sheet if you need more space):

Date	City & State	Hospital	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

16. Have any members of your child's family (mother, father, brothers, sisters, grandparents, aunts, uncles, etc.) had the following?

	Who?		Who?
Drug Addiction	_____	Emotional / Nervous	_____
Anemia	_____	Illness	_____
Arthritis	_____	Heart Trouble	_____
Asthma / Hay Fever	_____	Hearing Defect / Loss	_____
Birth Defect	_____	Kidney Disease	_____
Convulsions	_____	Mental Retardation	_____
Diabetes	_____	Thyroid Disease	_____
Sickle Cell Anemia	_____	Tuberculosis	_____

17. Please answer the following questions about the health of your child's immediate family (use a separate sheet if you need more space):

	Living	Date of Birth	Dead	Age at Death	Current Health / Cause of Death
Mother	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____
Father	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____
Brothers & Sisters	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	_____

18. When your child rides in the car, does (s)he ride in a car seat or wear a seat belt? Yes No

19. Are there any particular problems or stresses for your family right now; for example, marriage difficulties, problems with the other children, job pressures, financial problems, or illness in the family?

20. Is there any additional information which you think should be in your child's medical record?
