

Pediatric History Questionnaire

Patient Name: _____ Birth Date: _____

If 15 years or older, please provide patient's cell phone number: _____

Please list everyone living in the child's home:

Name	Relationship to Child	Name	Relationship to Child

Birth History: Birth Weight: _____ Gestational Age: _____ Delivery: Vaginal C-Section

List any complications: _____

Child's Medical History

List any current or prior medical conditions: _____

List any surgeries (and age at time of surgery): _____

List any allergies (medication/foods only): _____

Does the child take any medications, vitamins, or supplements? If so, please list: _____

Are you concerned about your child's development? If so, please explain: _____

Current school and grade (if applicable): _____

How does your child do in school? _____

Family History (Parents, Siblings, and Grandparents)

Relationship	Alcohol Abuse	Asthma	Birth Defects	Cancer	Depression	Diabetes	Drug Abuse	Early Death	Hearing Loss	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Learning Disabilities	Stroke	Vision Loss	ADHD/ADD	Anemia (other than pregnancy)	Anxiety	Autism	Autoimmune Disorders	Bipolar Disorder	Bleeding Disorders	Celiac Disease	Crohn's/Ulcerative Colitis	Eating Disorder	Immune Deficiency	Irritable Bowel Syndrome	Liver Disease	Migraines	Seizures	Thyroid Problems	Other (Comment Below)	
Mother																																		
Father																																		
Brother																																		
Brother																																		
Sister																																		
Sister																																		
Mat. Grandmother																																		
Mat. Grandfather																																		
Pat. Grandmother																																		
Pat. Grandfather																																		

Additional Comments: _____



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Patient's Signature Date Time Witness Signature Date Time

Signature of Authorized Person Date Time Relationship to Patient

Healthcare Provider Signature Date Time (Healthcare provider signature affirms the information above).

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

Interpreter Accepted _____ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)



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