Spring Valley Pediatrics PLLC

Patient's Name_____

Patient Medical History Questionnaire

Date of Birth_____ Form completed by_____ Date of completion_____

HOUSEHOLD Please list all those living in the child's home:

Name	Relationship to child	Date of birth	Health problems

BIRTH HISTORY

Birth weight_____ How many weeks gestation? _____

Did mother have any problems during pregnancy? _____

During pregnancy did mother ☐drink alcohol? ☐ smoke? ☐use any drugs or medications? _____

Was delivery ☐Vaginal? ☐ C-section? If C-section, for what reason? _____

Did baby have any problems right after birth? _____

Was initial feeding ☐breast? ☐bottle? Did baby come home with you from the hospital? _____

GENERAL Please provide details as necessary.

Does your child have any serious medical condition?	☐Yes	☐No	_____
Has your child has serious injuries or accidents?	☐Yes	☐No	_____
Has your child had any surgery?	☐Yes	☐No	_____
Has your child ever been hospitalized?	☐Yes	☐No	_____
Is your child allergic to medications?	☐Yes	☐No	_____
Is your child currently on any medications?	☐Yes	☐No	_____
Do you have any feeding or nutritional concerns?	☐Yes	☐No	_____
Has your child had any growth problems?	☐Yes	☐No	_____
Is your child up to date on immunizations?	☐Yes	☐No	_____

Please bring a copy of your child's immunization record to your first appointment at Spring Valley Pediatrics.

DEVELOPMENT

Are you concerned about your child's development?	☒Yes	☐No	_____
Are you concerned about his/her attention span?	☒Yes	☐No	_____

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing academically? _____

Is he/she in any special or resource classes? _____

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PAST MEDICAL HISTORY

Does your child have, or has he/she ever had the following? If so please provide details:

Chickenpox?	☐ Yes	☐ No	_____
Frequent ear infections?	☐ Yes	☐ No	_____
Problems with ears or hearing?	☐ Yes	☐ No	_____
Allergies?	☐ Yes	☐ No	_____
Problems with eyes or vision?	☐ Yes	☐ No	_____
Frequent strep throat or snoring?	☐ Yes	☐ No	_____
Asthma, bronchitis, bronchiolitis?	☐ Yes	☐ No	_____
Pneumonia?	☐ Yes	☐ No	_____
Heart problem or heart murmur?	☐ Yes	☐ No	_____
Anemia or bleeding problem?	☐ Yes	☐ No	_____
Blood transfusion?	☐ Yes	☐ No	_____
Frequent abdominal pain?	☐ Yes	☐ No	_____
Constipation requiring doctor's visit?	☐ Yes	☐ No	_____
Bladder or kidney infection?	☐ Yes	☐ No	_____
Bedwetting after 5 years of age?	☐ Yes	☐ No	_____
(for girls) Has she started her menses?	☐ Yes	☐ No	if so, when? _____
(for girls) Any problems with per periods?	☐ Yes	☐ No	_____
Any skin problem? (acne, eczema, etc)	☐ Yes	☐ No	_____
Frequent headaches?	☐ Yes	☐ No	_____
Seizures?	☐ Yes	☐ No	_____
Other neurological problems?	☐ Yes	☐ No	_____
Diabetes?	☐ Yes	☐ No	_____
Thyroid or other endocrine problem?	☐ Yes	☐ No	_____

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Use of alcohol, drugs, or tobacco? ☐ Yes ☐ No _____

Any other significant problem? ☐ Yes ☐ No _____