Holland Hospital

# Pediatric Patient Questionnaire

Patient: ______________________________ Date of Birth.: ____________

## Pregnancy and Birth

Mother's age at pregnancy ________ Any illness during pregnancy? ______________________

Medications during pregnancy? ______________________

Did you smoke, drink alcohol, or use illegal street drugs during your pregnancy? ______________________

Weeks of gestation: ________ Place of birth: ______________________

Type of delivery: ______________ Birth weight: ________ lbs ________ oz Length: ________ inches

Were there any complications during delivery? ______________________

Problems with infant at birth? ______________________

Were there any breathing problems at birth? ______________________ Jaundice at birth? Yes No

Other problems? ______________________

Were there any problems in the nursery or at home? ______________________

## Past Medical History

List allergies: ______________________

Medications taken on a regular basis: ______________________

Immunizations up to date? Yes No Do you have record? Yes No

| Hospitalizations: when, where, why: | Serious Injuries: when, where |
|---|---|
| 1. ______________________ | 1. ______________________ |
| 2. ______________________ | 2. ______________________ |
| 3. ______________________ | 3. ______________________ |

Has your child had any of the following (please check those that apply):

| | | | | |
|---|---|---|---|---|
| Red Measles | Anemia | Ear Infections | German Measles | Vision Problems |
| Chicken Pox | Bleeding tendency | Eczema | Rheumatic Fever | Joint Problems |
| Scarlet Fever | Blood transfusions | Hives | Strep Throat | Mumps |
| Asthma | Mumps | Hepatitis | Seizures | |
| Wheezing | Whooping Cough | Urinary Infections | Hearing Problems | |

Other: ______________________

## Feeding and Nutrition

Any know food allergies? ______________________

Appetite usually good? Yes No

Colic or feeding problems during the first three months of age? Yes No

Breast fed? Yes No Number of months: ________ Formula? Yes No Current brand: ______________

Vitamins? Yes No Brand______________ Special Diet? Yes No Explain: ______________

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## Family Profile

Parents: Married Separated Divorced

Father's Age: _______ Highest Level of Education: ___________________________ Father's Health: _________________________________

Mother's Age: _______ Highest Level of Education: ___________________________ Mother's Health: _________________________________

| Siblings: | Sibling 1 | Sibling 2 | Sibling 3 | Sibling 4 |
|---|---|---|---|---|
| Name | ________________________ | ________________________ | ________________________ | ________________________ |
| Age | ________________________ | ________________________ | ________________________ | ________________________ |

Additional Siblings: ____________________________________________________________________________

## Family Medical History

List all blood relatives of your child who have had the following problems. Use abbreviations (F) father (M) mother (B) brother (S) sister (MM) mother's mother (MF) mother's father (FM) father's mother (FF) father's father (A) aunt(U) uncle (C) cousin

Anemia / Blood Disorders: ____________________

Mental Retardation: ____________________

Alcoholism: ____________________

Aids: ____________________

Muscular Dystrophy: ____________________

Arthritis: ____________________

Heart Disease: ____________________

Cholesterol Problem: ____________________

Sudden Infant Death: ____________________

Early Deafness: ____________________

Asthma: ____________________

Drug Problem: ____________________

Cancer: ____________________

Cystic Fibrosis: ____________________

Tuberculosis: ____________________

Epilepsy / Seizures: ____________________

High Blood Pressure: ____________________

Migraines: ____________________

Birth Defects: ____________________

Diabetes: ____________________

## Development and Behavior

Please indicate the age at which your child:

Sat Alone: _________ Walked: _________ Used Sentences: _________ Toilet Trained: _________ Bicycled: _________

Your child's development compared to other children:

Your child's current grade in school: _________________

Does your child have problems in school? Yes No Explain: ____________________

Does your child have learning problems? Yes No Explain: ____________________

Does your child get along with other children? Yes No Explain: ____________________

Does your child have behavior problems? Yes No Explain: ____________________

Does your child have any bad habits? Yes No Explain: ____________________

Does your child wet the bed? Yes No Explain: ____________________

Does your child bite his/her nails? Yes No Explain: ____________________

Does your child have trouble sleeping? Yes No Explain: ____________________

Does your child have any hobbies / play sports? Yes No Explain: ____________________

Does your child use street or illegal drugs? Yes No Explain: ____________________

Anything else that you would like us to know about your child: ____________________________________________________________________