

# Mountainland Pediatrics Patient History Questionnaire

Name \_\_\_\_\_ M F Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Form Completed By \_\_\_\_\_ Biological parent of child? Yes No  
 If not biological parent, relationship to child: \_\_\_\_\_

## Household

Please list all those living in the child's home

Name	Relationship to Child	Birth Date	Heath Problems

## Birth History

Birth weight _____ Was the baby born at term? ____ Early? ____ Late? ____ If early, how many weeks' gestation? _____ Did mother have any illness or problem with her pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ During pregnancy, did mother: Smoke <input type="checkbox"/> Yes <input type="checkbox"/> No Drink Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No Use drugs or medications <input type="checkbox"/> Yes <input type="checkbox"/> No What: _____ When _____	Was the delivery <input type="checkbox"/> Vaginal? <input type="checkbox"/> Cesarean? If cesarean, why? _____ Did your baby have any problems right after birth? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ <hr/> Was initial feeding <input type="checkbox"/> Breast? <input type="checkbox"/> Bottle? Did your baby go home with mother from hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____
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## General

Do you consider your child to be in good health?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Does your child have any serious illness or medical condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Has your child had serious injuries or accidents?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Has your child had any surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Has your child ever been hospitalized?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Is your child allergic to any medicines or drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____

## Development

Are you concerned about your child's physical development?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Are you concerned about your child's mental or emotional development?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Are you concerned about your child's attention span?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____

If you child is in school:

How is his/her behavior in school? \_\_\_\_\_

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

How is he/she doing in academic subjects? \_\_\_\_\_

Is he/she in special or resource classes? \_\_\_\_\_

## Family Situation

Do you find time for yourself, for the other children, & your spouse? \_\_\_\_\_

What do you do when things seem to be getting to you? \_\_\_\_\_

Have you been in a relationship where you have been threatened or abused? \_\_\_\_\_

What do you do for a living? \_\_\_\_\_

## Family History

Have any family member had the following?

Deafness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Nasal Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Heart Disease (before 50 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
High blood pressure (before 50 years old old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
High cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Bleeding Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Diabetes (before 50 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Bed-wetting (after 10 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Epilepsy or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Drug abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Mental Illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Mental retardation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Immune problems, HIV, or AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Additional family history:	_____			

## Past History

Does your child have, or has he/she ever had:

Chicken pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
Frequent ear infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
Problems with ears or hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
Nasal allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
Problems with eyes or vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
Asthma, bronchitis, bronchiolitis or pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
Any heart problem or heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
Anemia or bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
Frequent abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
Constipation requiring doctor visits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
Bladder or Kidney infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
Bed-wetting (after 5 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
(for girls) Has she started her menstrual periods?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
(for girls) Are there problems with her periods?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
Any chronic or recurrent skin problem (acne, eczema etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
Convulsions or other neurologic problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
Thyroid or other endocrine problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
Any other significant problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	
Use of alcohol or drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____	

Today's Date: \_\_\_\_\_