Baylor Scott & White Family Medicine – Southwest Fort Worth

JOSEPH W. CAPPEL III, MD KIMBERLY EDEN, MD
CLARK MEADOR, DO LYNN SISK, RN-CS, FNP

PEDIATRIC HISTORY QUESTIONNAIRE

Patient's Name: ________________________________ Pt's Date of Birth: ____________ Pt's Age: _______

Patient is: ☐ Male ☐ Female Form Completed By ________________________________

Mother's Name: ________________________________ Phone#:Hm ______________Wk__________

Mother's Address: ____

Father's Name: ________________________________ Phone#: Hm ______________Wk__________

Father's Address: ____

Child lives with: (Everyone living in home with child, their ages and their relationship to child)

NAME	AGE	RELATIONSHIP

BIRTH HISTORY:

Birth Weight: ____________________ Was the delivery? ☐ Vaginal ☐ C-Section

Was the baby born? ☐ Full-term ☐ Early ☐ Late If C-Section was performed, why? ______________________

If early, how many weeks' gestation? ____ Did baby have problems right after birth? ☐ Yes ☐ No If yes, please explain:

____

Did mother have any illnesses or problems during pregnancy? ☐ Yes ☐ No Explain: ______________________

____

Was initial feeding by: ☐ Breast ☐ Bottle Other, please explain: ______________________

Did baby go home with mother from the hospital? ☐ Yes ☐ No If no, explain: ______________________

During pregnancy, did mother? Smoke: ☐ Yes ☐ No Drink Alcohol: ☐ Yes ☐ No Use drugs / medications: ☐ Yes ☐ No

If yes, please list all drugs / meds taken, the dosage and when taken during pregnancy:

____

SURGICAL / HOSPITALIZATION HISTORY: (List all surgeries / hospitalizations)

____

____

ALLERGIES: (List all allergies and type of reaction to each)

____

____

Patient Name: ________________________________ **Account#** ______________________

PAST HISTORY: (Please check all that apply)

- ☐ Abdominal Pain (Frequent)
- ☐ Alcohol / Drug Abuse
- ☐ Anemia
- ☐ Asthma
- ☐ Anxiety
- ☐ Bed-wetting (after 5 yrs old)
- ☐ Bladder / Kidney Infections
- ☐ Blood Transfusions
- ☐ Bronchitis
- ☐ Chickenpox
- ☐ Constipation (Requiring Dr. visit)
- ☐ Convulsions / Neurological Problem
- ☐ Depression
- ☐ Diabetes
- ☐ Ear Infections (Frequent)
- ☐ Eye / Vision Problems
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Heart Problem / Murmur
- ☐ Seizures
- ☐ Skin Problems (Acne, eczema)
- ☐ Thyroid / Endocrine Problem
- ☐ Other: ______________________

Girls Only:

Started menstrual cycle? ☐ Yes ☐ No Problems with periods? ☐ Yes ☐ No If yes, please explain: ______________________

____

MEDICATIONS: (List all medications, prescribed and over the counter, herbs and supplements)

	DRUG	STRENGTH	HOW OFTEN	LENGTH OF TIME TAKEN
EX:	Advil	200mg	3 times a day	6 months

IMMUNIZATIONS: (Please list or provide copy of **current** immunization record)

	1	2	3	4	5
Dtap	______	______	______	______	______
Tdap / Td	______	______			
Hepatitis A	______	______			
Hepatitis B	______	______	______		
HIB	______	______	______	______	
IPV (Polio)	______	______	______	______	
Menningitis	______				
MMR	______	______			
Prevnar (Pneumonia)	______	______	______	______	
Varicella (Chickenpox)	______	______			

FAMILY HISTORY:

Please mark in the brackets ( ) any medical conditions your family has had using the following abbreviations: Mother (**M**), Father (**F**), Brother (**B**), Sister (**S**), Grandparent (**GP**), Aunt (**A**), Uncle (**U**)

For example, if the child's Aunt and Mother had Diabetes: (**A, M**) Diabetes

- ( ) Anemia/Blood Disorder
- ( ) Asthma
- ( ) Arthritis
- ( ) Cancer, Type _______________
- ( ) Colon Polyps
- ( ) Depression / Anxiety
- ( ) Diabetes
- ( ) Elevated Cholesterol
- ( ) Emphysema / COPD
- ( ) Glaucoma
- ( ) Heart Disease
- ( ) High Blood Pressure
- ( ) Kidney Disease
- ( ) Migraine
- ( ) Osteoporosis
- ( ) Prostate Cancer
- ( ) Seizures
- ( ) Stroke / TIA
- ( ) Substance Abuse
- ( ) Thyroid Disorder
- ( ) Tuberculosis

Patient Name: ____ **Acct#:** ____________________________