BAYLOR FAMILY MEDICINE SOUTHWEST
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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)

_____

_____

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#: _____