Lifetime Family Care, PLLC

**Pediatric Patient Questionnaire** (< than 12 y/o)

Date: _____

## IDENTIFICATION INFORMATION

Name: _____ DOB: _____ Age: _____ Sex: Male Female

Address: _____City: _____ State: _____ Zip: _____

Home Phone Number: ( ) _____ Alternate Number: ( ) _____

Name of person to contact in case of an emergency: _____ Phone No._____

Child Care Arrangements (if adults work outside the home): _____

Child's School:_____ Grade:_____(if applicable)

**Please fill out as completely as possible. All information will be kept confidential.**

## HEALTH CARE STATUS

1. Where has your child gone for checkup until now? _____
2. What is the date of your child's last check up? _____
3. What is the date of your child's last dental checkup? _____
4. Is your child under treatment now for an illness or medical condition? No Yes
   If yes, for what? _____
   With whom? _____
5. Has your child had allergic reaction to any medications, food or bee stings? No Yes
   If yes, please list: _____
6. Has your child had reactions to any immunizations? No Yes
   If yes, please list: _____
7. Does your child take any medications regularly? *(Please include any over the counter medicine such as Tylenol or vitamins)* No Yes
   If yes, please list: _____
8. Do you have a record of your child's immunizations? No Yes
9. Has your child had any surgeries? No Yes
   If yes, please list:_____

## PREGNANCY AND BIRTH

1. Did mother have any illnesses during pregnancy? No Yes
2. Did mother use any medication other than vitamins/iron? No Yes
3. Wash the baby born on time? Or Premature (less 37 weeks) No Yes
4. What was the baby's birth-weight? _____
5. Did the baby have any trouble starting to breathe? No Yes
6. Was there any complications during or after birth? No Yes
   If yes, explain: _____
7. Did the baby have any trouble in the hospital? (Jaundice, infections, other) No Yes
   If yes, what kind? _____

## FAMILY HISTORY

Dad's Name: _____ Mom's Name: _____

Dad's Age: _____Height:_____ Mom's age: _____ Height:_____

Any medical problems? No Yes Any medical problems? No Yes

_____ _____

List general health, age and sex of any brothers and sisters:

Name General Health Age Sex

_____

_____

_____

_____

_____

Have any of your children died? No Yes

Have any blood relatives had any of the following illnesses? *(Parent, grandparent, brother, sister, aunt, uncle)* If so, please indicate the relationship to the child.

Anemia _____

Asthma _____

Allergies _____

Blood Disease _____

Cancer _____

Diabetes _____

Epilepsy _____

Glaucoma _____

High Blood Pressure _____

Heart Trouble _____

Mental Illness _____

Rheumatoid Arthritis _____

Tuberculosis _____

Drug Problems _____

Alcohol Problems _____

Other _____

## FEEDING AND NUTRITION

1. Is your child's appetite usually good? No Yes
2. Was there severe colic or any unusual feeding problems during the first months of life?
   No Yes
3. Do any foods disagree with your child? No Yes
   If so, what? _____
4. Does your child take vitamins? No Yes

## REVIEW OF STATUS

1. Has your child had frequent ear infections? No Yes
2. Has your child had any eye or vision problems? No Yes
3. Has your child had any problems with teeth? No Yes
4. Does your child have frequent colds or sore throats? No Yes
5. Is there asthma, pneumonia or a recurrent cough? No Yes
6. Does your child have a heart murmur or any heart problems? No Yes
7. Does your child have any problems with urination? No Yes
8. Does your child have any problems with diarrhea or constipation? No Yes
9. Have there been any convulsions or other problems with the nervous system? (for example: seizures, paralysis, etc) No Yes
10 Has your child had any problems with eczema hives or other skin conditions? No Yes
11. Has your child ever been anemic? No Yes

Please list any other medical problems or explain any medical problems to questions above:

_____

_____

_____

_____

## SAFETY / ENVIRONMENT

1. Do you live in a *private house, apartment, mobile home, other?* (Please circle)
2. Is there a working smoke alarm on each floor where you live? No Yes
3. Does your child always use a seat belt/ car seat in a car? No Yes
4. Are there any smokers in the household? No Yes
5. Are there any problems with the conditions of your home, such as peeling paint, insects, rats or mice? No Yes

6. Has your house ever been evaluated for high lead levels or have you ever been told your house has high lead levels by the city? No Yes

7. Does your child wear a helmet when riding a bike? No Yes

8. Do you have any firearms in the house? No Yes

9. Have any of the child's caregivers been trained in CPR? No Yes

10. Do Do you have the phone number for POISON CONTROL? No Yes

**WHAT IS THE REASON FOR TODAY'S VISIT?**

_____

_____

_____

**OTHER COMMENTS NOT COVERED ABOVE**

_____

_____

_____

Name of person completing form: _____ Relationship: _____

Physician Signature: _____ Date: _____