PEDIATRIC BRIEF HEALTH QUESTIONNAIRE

Patient's Name ____ Age ______ DOB: _______________

Reason for today's visit: ____

VACCINE HISTORY

Please provide a copy of his/her vaccine record.

PROBLEM LIST

Please put a check next to the problem and fill in the year diagnosed. If child does NOT have any of these problems, check NONE.

Type	Year	Type	Year	
( ) Allergies	_______	( ) Eczema	______	
( ) Asthma	_______	( ) GERD	______	
( ) ADD/ADHD	_______	( ) Seizures	______	**( ) NONE**

( ) Other ____

SURGICAL HISTORY

Please list all surgeries your child has had and give the year of that surgery.

	Type	Year
1.	____	________
2.	____	________

CURRENT MEDICATIONS

Please list any and all medications or pills that child is presently taking regularly or from time to time. If none, please state "none".

Drug Name	mg	How often?	Regularly or as needed	Drug Name	mg	How often?	Regularly or as needed

MEDICATION ALLERGIES

If child is allergic to any medication(s), please list them. Give Name of medication and type of reaction (Rash, Shock, Respiratory problems, GI upset, Unknown, Other). If none, please state "none".

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FAMILY HISTORY

Put a check next to the disease and circle the family member (M = Mother, F = Father, B/S = Brother or Sister, GP = Grandparent) who has had this disease.

( ) Allergies	F M B/S GP	( ) Asthma	F M B/S GP	( ) Seizures	F M B/S GP
( ) Breast Cancer	M S GP	( ) Diabetes	F M B/S GP	( ) Melanoma *	F M B/S GP
( ) Colon Cancer	F M B/S GP	( ) Heart Disease	F M B/S GP	( ) Prostate Cancer	F B GP

***This is a serious type of skin cancer that spreads and **not** the regular, more common skin cancer varieties.

Please continue on other side

SOCIAL HISTORY

Birthplace: (State/Country) __________________ Year moved to area______________ from ______________________

Household members: Mother _____ Father _____ Brother(s) _____ how many? _____ Sister(s) _____ how many? _____ Other ___________________________

Pets in the home? _____ Yes _____ No
Type: ___________________________________
Smoking in the home? ____ Yes ____ No
Firearms in the home? ____ Yes ____ No
Gun Locks __ Y __ N Safe? ___Y ___ N

The Federal Drug Administration (FDA) suggests that doctors document a patient's race/ethnicity according to the following categories. This is being requested in that some medications may be better for (or, perhaps, harmful to) certain groups. Please specify by checking one (or more, if that better clarifies your heritage) of the following:

Hispanic / Latino ____ Native Hawaiian/Pacific Island _____ Asian ____
Black / African American ____ Am. Indian /Alaska Native _____ White ____

BIRTH HISTORY

Delivery: ( ) Vaginal ( ) Cesarean (C-section) Birth Weight: _____________________
Complications: ____

Complete information below only if here for sports or camp physical or well child exam

DIETARY HISTORY

Birth to 2 years: (Skip to next section if age 2 or older)

( ) **Breast feeding** Duration: ________ minutes every __________ min/hour(s)

( ) **Formula** ( ) Enfamil ( ) Enfamil w/iron ( ) Similac ( ) Similac w/iron Other: ___________
How much?: ________ oz. every _________ min/hour(s)

( ) **Cereal** ( ) once a day ( ) twice a day ( ) three times a day ( ) more than three times a day

( ) **Baby foods**
( ) Vegetables – type: ________________________________ times per day: ________________
( ) Meats – type: ____________________________________ times per day: ________________
( ) Fruits - type: ____________________________________ times per day: ________________

For children over age 2 years:

Servings per day

( ) Dairy _________________________
( ) Fruits _________________________
( ) Vegetables ________________________
( ) Meats _________________________

EDUCATION LEVEL: School: ____Grade level: ________

Please list concerns and/or questions you would like to discuss during today's visit.
____
____
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