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 _____ Pets in the home? _____ Yes _____ No
Father _____ Type: _____
Brother(s) _____ how many? _____ Smoking in the home? ____ Yes ____ No
Sister(s) _____ how many? _____ Firearms in the home? ____ Yes ____ No
Other _____ 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.
_____
_____
_____