

# PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

Age 0-13 years

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Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

## **Maternal History:**

Mother's age at delivery \_\_\_\_\_ Number of Pregnancies \_\_\_\_\_ Number of Deliveries \_\_\_\_\_ Blood Type \_\_\_\_\_

Abortions/Miscarriages: \_\_\_\_\_ Length of Pregnancy \_\_\_\_\_ Vaginal or C section Delivery \_\_\_\_\_

Complications of pregnancy, labor & delivery, medications during pregnancy \_\_\_\_\_

Child's problems at birth: \_\_\_\_\_

## **Birth History:**

Birth Weight \_\_\_\_\_ Lbs \_\_\_\_\_ Oz. Breast or Bottle Fed? \_\_\_\_\_

APGAR Score \_\_\_\_\_ / \_\_\_\_\_ if known Child's Blood Type \_\_\_\_\_ Child's Sex Male/Female

WIC Yes/No

## **Medical History:**

Hospitalizations/Surgeries: \_\_\_\_\_

Chronic Health Problems: \_\_\_\_\_

Medications: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

## **Family History:**

Name

DOB

Health Status

Occupation

Mother \_\_\_\_\_

Father \_\_\_\_\_

## **Siblings Brother/Sisters:**

Primary Caregiver if not parents: \_\_\_\_\_

## **Does anyone in the family have any of the following? (Please circle)**

Anemia Arthritis Bleeding Deafness Diabetes Kidney Disease Birth Defects

Thyroid Disease Asthma Hepatitis HIV Migraines Alcohol/Drug abuse Seizures

Heart Disease Hypertension Cancer Tuberculosis Retardation Emotional Problems Suicide

## **Social History:**

Pets \_\_\_\_\_ Smokers inside/Outside \_\_\_\_\_

What type of heating system do you have? Central-Wood-Electric-Gas-Other \_\_\_\_\_

What type of cooling/air conditioning system? Central-Window Air Conditioners-Fans-Other \_\_\_\_\_

Do you have city water or well water? \_\_\_\_\_ Who live in household? \_\_\_\_\_

Daycare or school attended \_\_\_\_\_

Hobbies/Activities/Sports

Seathelt/Car Seat