Manasquan Pediatrics

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INITIAL HEALTH HISTORY QUESTIONNAIRE

Please list below all those living in the child's home:

Name and Relationship to Child:	Date of Birth:	Health Problem:

Are there any family members not living with the child: □ Yes □ No

BIRTH HISTORY:

Birth Weight:_____ Discharge Weight:_____ Delivery Type: □ Vaginal □ Cesarean

If Cesarean, please state reason:_____

Was the baby born: □ Full-Term □ Late □ Early-how many weeks early? _____

Did your baby have problems after birth? _____

Initial feeding: □ Breast □ Bottle- formula type: _____

During pregnancy did the mother smoke? □ Yes □ No

Any medications taken during the pregnancy? □ Yes □ No

GENERAL INFORMATION:

Do you consider your child to be in good health? □ Yes □ No

Does your child have any serious illness or medical conditions? □ Yes □ No

If yes, please state illness:_____

Has your child had any serious injuries or accidents? □ Yes □ No

If yes, please state injury or accident: _____ Date: _____

Has your child ever had surgery? □ Yes □ No

If yes, please state type of surgery: _____ Date: _____

Has your child ever been hospitalized? □ Yes □ No

If yes, please state reason: _____ Date: _____

Is your child allergic to any medications or drug? □ Yes □ No

If yes, please state drug: _____

Is your child on any OTC medicines on a regular basis? □ Yes □ No

If yes, please state medicine and frequency: _____

Is your child on any prescribed medications? □ Yes □ No

If yes, please state medication and frequency: _____

Does your child see any medical specialists? □ Yes □ No

If yes, please indicate specialist name: _____

DEVELOPMENT:

Are you concerned with your child's physical development? □ Yes □ No

Are you concerned with your child's mental/emotional development? □ Yes □ No

Are you concerned about your child's attention span? □ Yes □ No

If your child is in school, are there any academic/behavioral problems? □ Yes □ No

PAST HISTORY:

Does your child have or has he or she ever had?

Chicken Pox	□ Yes	□ No	If yes, when: _____
Frequent ear infections	□ Yes	□ No	
Problems with ears or hearing	□ Yes	□ No	
Nasal allergies	□ Yes	□ No	
Problems with eyes or vision	□ Yes	□ No	
Asthma, bronchitis, pneumonia	□ Yes	□ No	If yes, when: _____
Any heart problem or heart murmur	□ Yes	□ No	
Anemia or bleeding problems	□ Yes	□ No	
Blood transfusion	□ Yes	□ No	If yes, when: _____
Frequent abdominal pain	□ Yes	□ No	
Constipation that requires physicians visit	□ Yes	□ No	
Bladder or kidney infection	□ Yes	□ No	
Bed wetting after 5 years of age	□ Yes	□ No	
Any chronic or recurrent skin problems	□ Yes	□ No	If yes, what type: _____
Frequent headaches	□ Yes	□ No	
Convulsions or other neurologic problems	□ Yes	□ No	
Diabetes	□ Yes	□ No	
Thyroid or other endocrine problems	□ Yes	□ No	
Use of alcohol or drugs	□ Yes	□ No	If yes, type: _____

FOR GIRLS:

Has she started her menstrual periods	□ Yes	□ No	If yes, when: _____
Are there any problems with her periods	□ Yes	□ No	

FAMILY HISTORY:

Chronic/genetic illness □ Yes □ No

If yes, what type of illness: _____ Which family member: _____

SIDS/Sudden cardiac death □ Yes □ No

Please include anything else you would like us to know about the health of your child:

_____

_____

_____