PEDIATRIC HEALTH INFORMATION QUESTIONNAIRE (12 AND UNDER)

Child's Last Name _____ First_____ DOB:_____ Today's Date_____

MEDICAL CARE INFORMATION Please answer these questions on behalf of your child

Pedatrician/PracticeName_____Phone _____
Date of last visit _____ Reason _____
Medications your child is currently taking _____
Vaccination history: _____ Up to date _____ Delayed _____ Exempt _____ Have questions about vaccines
According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.) Does this apply to your child? __Yes __No
Is your child currently or previously been involved in any high impact or contact type sports? Yes No If yes, please describe:

_____

Has your child ever been involved in a car accident? Yes No Date:_____
Has your child ever been seen in an emergency room? Yes No Date and reason:

_____

PRENATAL HISTORY

Birth Attendant: __ OB __ CNM __ Lay Midwife __ Other
Location of Birth: __ Home __ Birthing Center __ Hospital __ Other
Complications during pregnancy: Yes No Please describe:

_____

Ultrasounds during pregnancy: Yes No How many:

_____

Medications during pregnancy: Yes No Please describe:

_____

Drug use during pregnancy (include alcohol and tobacco): Yes No Please describe:

_____

Birth intervention: Forceps Vacuum Ceasarian: Planned or Emergency (circle one)
Complication during delivery: Yes No Please describe:

_____

Birth weight: _____ Birth length:_____ APGAR score:

_____

FEEDING HISTORY

Breast fed: Yes No
How long? _____
Formula fed: Yes No
How long? _____
Food allergies or intolerances: Yes No Please describe:

_____

DEVELOPMENTAL HISTORY

Females only, onset of menstrual cycle: Yes No Age _____

Health concerns for your child, check all that apply:

__Digestion/Colic __ Constipation __ ADD/ADHD __ Developmental Delays __ Genetic Disorder
__ Ear Infections __ Diarrhea __ Poor Diet __ Poor Posture __ Weak Immune __ Infections
__ Asthma/Allergies __ Lack of Exercise __ Lack of Sleep Other