DESERT SENITA
COMMUNITY HEALTH CENTER
Quality, Local, Affordable Health Care for All

PEDIATRIC HEALTH QUESTIONNAIRE

Child's Last Name:	Child's First Name:
Date of Birth:	Phone Number:

The purpose of this questionnaire is to gather important medical and social information about your child which will help us provide the best possible care. Please answer as completely as you can.

FAMILY HISTORY (please include any deceased members of immediate family)

		Age:	Health problems & illness:
Father's First, Last Name:			
Mother's Maiden Name:			
1.Sibling:			
2.Sibling:			
3. Sibling:			

Father's Occupation: ____________________________ Mother's Occupation: __________________________
Does the mother live in the same residence as child? YES □ NO □ Is the child regularly in daycare? YES □ NO □
Does the father live in the same residence as child? YES □ NO □ Is the child regularly with baby sitter? YES □ NO□
Other people living with family: ____

Has the child or any other family member had any of the following conditions? (If yes, please state who)

Diabetes	Mental retardation	Drug problem
Asthma	Birth deformity	Mental Illness
Allergies/ Hay Fever	Leukemia	Any others:
Tuberculosis	Cancer	a.)
Kidney Trouble	Epilepsy	b.)
Arthritis	Heart disease	c.)
High blood pressure	Drinking problem	d.)

PREGNANCY AND BIRTH HISTORY

Name and location of obstetrician or other provider of care during pregnancy: ___________________________
Mother's Age during pregnancy: ________________
Did the mother have problems during pregnancy with any of the following? If so please check:

Problem:	YES:	NO:	If yes, explain	Problem:	NO	YES	If Yes, explain
Infections				Severe Vomiting			
Bleeding				Diabetes			
High Blood Pressure				Other			

Did the mother take any medications during pregnancy besides iron and vitamins? If so, please list:
____

Were any of the following complications of labor?

Complication	NO	YES	If yes, please explain	Complication	NO	YES	If yes, please explain
Breech				C-section			
Induced Labor				Other			

Baby was born: On time? _______________ Baby's Birth Weight?_________________
Late? How many weeks?_____________
Early? How many weeks?_____________

Did the baby have any problems in the delivery room or in the nursery?

Problem:	YES	NO	Problem:	YES	NO
Difficulty Breathing			Jaundice		
Needed Oxygen			Feeding Problem		
Infections			Other		

Did Baby go home with mother? YES □ NO □

MEDICAL HISTORY Child's general state of health: Good □ Fair □ Poor □

Hospital admissions, operations please list below:

Hospital:	Date:	Reason:

Please list any serious accidents or broken bones: ____

Skin Tests: (most recent dates) ______________________________________TB (Tine, PPD)________________________________

Do you feel that your child is developing normally in comparison to other children? YES □ NO□

If NO please explain?

____

____

Has your child had any serious or persistent problems with any of the following? If yes, please explain

Problem:	YES	NO	If yes, please explain	Problem:	YES	NO	If yes, please explain
Skin				Learning Problems			
Eyes or vision				Ears or hearing			
Speech				Behavior(home/school)			
Teeth				Urinary infections			
Feeding				Bedwetting			
Bowel Problem				Sleeping			
Overweight				Other			

YES NO

□ □ Has the child had any bad reactions to medications? If yes, which ones? ____________________________________

□ □ Does your child take any medications or treatments regularly? If yes, state which______________________________

□ □ Does your child use an approved carseat when in the car?

□ □ Are all poisons or medications out of the reach of your children in the home?

□ □ Do you know what to do in case of accidental poisoning?

□ □ Are you careful while cooking or handling hot foods when children are in the kitchen?

When did your child last visit the dentist? ____

I represent each and all of the foregoing answers to be true and complete.

Parent or
Guardian Signature: ____ Date: __________________________

Physician Signature: ____ Date: __________________________