TRI COUNTY PEDIATRICS QUESTIONNAIRE

Patients Name: ____________________________________ Date of Birth: ________________ Relationship to Patient _______________________

Please Circle Yes or No, explain where required. N/A - Not Applicable

PREGNANCY & BIRTH:
Mothers Health During Pregnancy? ________________________
Medications During Pregnancy? YES or NO
Hospital Name: ____
Gestation Weeks ____
Type of Delivery? C-Section Vaginal
Birth Weight _____________________________________
Newborn Hearing Test : PASSED FAILED
HEP B Vaccine given at birth? YES NO
Complications? YES NO Breech? YES NO
Problems with baby during birth: _____________________________
Jaundice? YES NO
Smoking, Alcohol, Street drugs, during pregnancy? YES NO
Other problems during Pregnancy? ____________________________

CHILD'S PAST MEDICAL HISTORY
Allergies to Medicine? YES NO / Food? YES NO
Any Surgeries? YES NO
Immunizations up to date? YES NO
Hospitalization (when, where, why)? __________________________
Serious Injuries (when, where)? ______________________________

Asthma YES NO	Vision Problems YES NO
Allergic Rhinitis YES NO	Hearing Problems YES NO
Ear Infection YES NO	Joint Problems YES NO
Eczema/Hives YES NO	Skin Problems YES NO
Autism YES NO	Developmental Problems Y N
Seizures YES NO	Heart Problems YES NO
UTI / Genital Urinary Y N	Abdominal Problems YES NO
Speech Delay YES NO	ADD/ADHD/Psychiatric Y N
Blood Disorder YES NO	Depression YES NO
Neurological / CP YES NO	Kidney Problem YES NO

NUTRITION
Appetite usually good? YES NO
Colic or feeding problems during first 3 months? YES NO
Breast fed? YES NO / Formula YES NO Brand _____________
Drinks Milk? YES NO
Eats Fruit? YES NO
Eats Vegetables? YES NO

SOCIAL HISTORY
Language Spoken at home: English Spanish Other:____________
Child Lives with:
Mother______ Father______ Both_______ Grandmother_______
Aunt _______ Guardian _______ Father/Mother Involved YES NO
Smokers at home? YES NO / Pets? YES NO

DEVELOPMENT & BEHAVIOR
Age at which child:
Sat Alone ___________
Walked ____________
Used Sentences / Speech ____________
Teeth ______________

SCHOOL AGE CHILD
Grade in school ______________ Likes School YES NO
Problems in school? YES NO
Learning Problems? YES NO
Behavior Problems? YES NO
Bad Habits? YES NO
Bedwetting? YES NO / Sleeping well YES NO
Smoking? YES NO
Use street or illegal drugs? YES NO
Any Hobbies or sports? _________________________________

FAMILY MEDICAL HISTORY
List all blood relatives of your child who have had the following problems:

Allergies: ____
Asthma: ____
Allergic Rhinitis: ____
Eczema: ____
Blood Disorder: ____
Mental Illness: ____
Drug Problem: ____
Cancer: ____
Arthritis/Hip Disorder: ___________________________________
Epilepsy/Seizures: _______________________________________
Heart Disease/Cholesterol Problem: ________________________
High Blood Pressure: _____________________________________
Migraine: ____
Deafness: ____
Diabetes: ____
Stomach Problems: ______________________________________
Thyroid Problems: _______________________________________
Vision Problems: ____

Explain other concerns:

List of Medications:

Signature: ____ Date: ___________________