WESTSIDE PEDIATRIC CLINIC

Dear Parent,

By filling out this questionnaire a more complete record of your child is obtained. It also gives us permanent history which we can refer to later. It saves your time and ours. Answer any questions you can, don't worry about those you skip. We will discuss with you and items which either you or we believe should be explained more fully.

Patient's Last, **First** **Age** **Date**

Pregnancy, Birth and Newborn History

1. Did you have an illness during your pregnancy? Yes No
2. Did the baby come on time? Yes No
3. How old were you when the baby was born? _____ Years
4. How many times have you been pregnant? _____
5. How many hours did the labor last? _____ Hours
6. How much did the baby weigh at birth? ____lbs.___ozs.
7. Did your baby have any trouble starting to breath? Yes No
8. Did the baby have any trouble while in the hospital? Yes No

Medical History

1. Does your child have food or medication allergies? Yes No
2. Does your child have a history of surgery or hospitalizations? Yes No
3. Does your child have a history or frequent constipation? Yes No
4. Does he/she have a history of frequent diarrhea or vomiting? Yes No
5. Does he/she often have abdominal pain? Yes No
6. Does he/she get nasal allergies? Yes No
7. Does he/she have asthma or a history of recurrent wheezing? Yes No
8. Does he/she have eczema or hives? Yes No
9. Does he/she have a history or ear infection? Yes No
10. Does he/she have a history of recurrent sinus infections or pneumonia? Yes No
11. Does he/she have a history of hearing problems? Yes No
12. Does he/she have a history of vision problems? Yes No
13. Does he/she have a history of dental problems? Yes No
14. Does he/she have a history of urinary tract infections or urinary problems? Yes No

15. Does he/she have a history of seizures? Yes No
16. Do you have any concerns about his/her development? Yes No
17. Do you have any concerns about his/her behavior? Yes No
18. Does he/she have a history of frequent headaches? Yes No

Family History

1. List first name, age, general health, and years of education of the child's parents:

Mother:

Father:

2. List names, age, general health of child's brothers and sisters:

1. _____
2. _____
3. _____
4. _____

3. Have any of your children died? Yes ☐ No ☐

4. Check any of the following disease that this child's parents, brothers, sisters, grandparents, aunts, uncles or first cousins have had:

☐ School Problems	☐ Diabetes	☐ High Blood Pressure	☐ Deformities
☐ Mental Illness	☐ Seizures	☐ Heart Disease	☐ Early Death
☐ Asthma	☐ Allergies	☐ Inherited Diseases	

5. What doctors have taken care of your child in the past?

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