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 any items which either you or we believe should be explained more fully.

| Patient's Last Name | 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. oz. |
| 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 your child have a history of frequent diarrhea or vomiting? | Yes No |
| 5. | Does your child have abdominal pain often? | Yes No |
| 6. | Does your child get nasal allergies? | Yes No |
| 7. | Does your child have asthma or a history of recurrent wheezing? | Yes No |
| 8. | Does your child have eczema or hives? | Yes No |
| 9. | Does your child have a history of ear infection? | Yes No |
| 10. | Does your child have a history of recurrent sinus infections or pneumonia? | Yes No |
| 11. | Does your child have a history of hearing problems? | Yes No |
| 12. | Does your child have a history of vision problems? | Yes No |
| 13. | Does your child have a history of dental problems? | Yes No |
| 14. | Does your child have a history of urinary tract infections or urinary problems? | Yes No |

15. Does your child have a history of seizures? Yes No
16. Do you have any concerns about your child's development? Yes No
17. Do you have any concerns about your child's behavior? Yes No
18. Does your child have a history of frequent headaches? Yes No

**Family History**

Please list each name, age, and general health for each parent.

Parent Name: _____

Parent Age: _____

Parent General Health: _____

Parent Name: _____

Parent Age: _____

Parent General Health: _____

Please list names, age, general health of child's brothers and sisters:

1. _____
2. _____
3. _____
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 __ Inherited Diseases

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