Four Seasons Pediatrics, LLC – Pediatric History Questionnaire

Patient Name _____ **Date of Birth** ____/_____/_____

Family Members:	**Name**	**DOB**	**Occupation/ Status**	**Employer**
☐ Father	_____	_____	_____	_____
☐ Stepfather	_____	_____	_____	_____
☐ Mother	_____	_____	_____	_____
☐ Stepmother	_____	_____	_____	_____
☐ Brothers and Sisters (please indicate if they are half or step siblings):				
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Are the **biological** parents living together? ☐ Yes ☐ No

Birth History:

Delivery - ☐ Vaginal ☐ C-section. What hospital was your baby born at? _____

If Cesarean delivery describe reason: _____ Was your baby full term? ☐ Yes ☐ No

Group B Strep Cervical Culture: ☐ Positive ☐ Negative.

Mother's Heb B test was : ☐ Positive ☐ Negative

Mother's Rubella Status was: ☐ Immune ☐ Nonimmune

Birth weight: _____lbs _____oz. Discharge weight from the hospital: _____lbs _____oz.

Was the hearing test passed in the hospital: ☐ Yes ☐ No

Please list any problems in the Nursery _____ ☐ None

Past Medical History – please list all medical problems and age of onset (place a comma after each problem):

_____

Past Surgeries - please list type and year : _____ ☐ None

Medications - please list medication currently being taken: _____ ☐ None

Allergies to food or medication – ☐ Yes ☐ No If YES list the food or medication and what reaction occurred:

_____

Development – please list any developmental problems your child has had: ☐ None

_____

Family History – please check those that are positive. Please check 'M' for maternal and 'P' for paternal, then list the relationship to the PATIENT (e.g grandfather). If both maternal and paternal please notate which by using 'M' or 'P' after the relationship (e.g. grandfather (M), uncle (P).

☐ Alcoholism ☐ M ☐ P _____ ☐ High Cholesterol ☐ M ☐ P _____

☐ Allergies ☐ M ☐ P _____ ☐ Hypertension ☐ M ☐ P _____

☐ Anemia ☐ M ☐ P _____ ☐ Kidney Disease ☐ M ☐ P _____

☐ Asthma ☐ M ☐ P _____ ☐ Mental Retardation ☐ M ☐ P _____

☐ ADHD ☐ M ☐ P _____ ☐ Heart Attack/ stroke ☐ M ☐ P _____

☐ Cancer ☐ M ☐ P _____ ☐ Obesity ☐ M ☐ P _____

☐ Cystic Fibrosis ☐ M ☐ P _____ ☐ Seizures ☐ M ☐ P _____

☐ Diabetes ☐ M ☐ P _____ ☐ Tuberculosis ☐ M ☐ P _____

☐ Eczema ☐ M ☐ P _____

Patient Name _____ DOB _____/_____/_____

Other History

Is there any other behavioral health history for the family or patient (e.g. schizophrenia, stress, alcohol, prescription drug abuse, illegal drug use) _____

Are you anticipating or are you currently using a daycare for your child? ☐ Yes ☐ No

Was your house built before 1960? ☐ Yes ☐ No

Does anyone in the family currently smoke? ☐ Yes ☐ No

If YES, who? _____

Do they smoke inside? ☐ Yes ☐ No

Has anyone in the house ever smoked (in or outside)? ☐ Yes ☐ No

If YES, who? _____

Please list your water district (e.g. Clifton Park Water Authority) _____.

_____ _____ _____

Name of person who filled out form Relationship to child Date

_____ _____

Provider signature – Info reviewed and entered into EMR **Date**