Four Seasons Pediatrics, LLC – Pediatric History Questionnaire

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

Family Members:	**Name**	**DOB**	**Occupation/ Status**	**Employer**
☐ Father	________________________	___________	____________________	____________
☐ Stepfather	________________________	___________	____________________	____________
☐ Mother	________________________	___________	____________________	____________
☐ Stepmother	________________________	___________	____________________	____________

☐ Brothers & 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

____

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Family History – please check those that are positive(P).

Medical Condition	Mom	Dad	Child's Sister	Child's Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Anemia												
Alcoholism												
Allergies												
Asthma												
ADHD												
Cancer												
Cystic Fibrosis												
Diabetes												
Eczema												
High Cholesterol												
Hypertension												
Kidney Disease												
Mental Retardation												
Heart Attack/Stroke												
Obesity												
Seizures												
Tuberculosis												

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**