premierpediatrics
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PEDIATRIC QUESTIONNAIRE

DEMOGRAPHICS

Childs Name: _____ Child's DOB: _____

Family Members living in the home (please incl ages of children): _____

_____

What is child's living situation? (if not living with both parents): _____

Does child attend school or daycare? _____

BIRTH HISTORY

What was child's Birth weight? _____Was child born full term? _____

Any complications of pregnancy/delivery or newborn course?

_____

During pregnancy, did mother use tobacco, alcohol, or other drugs of abuse?

_____

PAST MEDICAL HISTORY

Do you consider your child to be in good health? _____

Does your child have any food or medication allergies? _____

Does your child take any prescription medication or otc medication regularly?

_____

Has your child ever had any surgeries? _____

Has your child ever been hospitalized? _____

Has your child ever sustained any major injuries? _____

Has your child ever been diagnosed with a developmental delay?

_____

Do you have any other concerns about your child's health not detailed above?

_____

FAMILY HISTORY

Are there any known genetic or childhood disorders that run in your family?

_____

Has there been any history of sudden death in an individual under 35 years of age in your family?

_____

Are child's biological parents and siblings all living? _____

Please detail any significant past medical history of any first-degree relatives that may be pertinent to child's health:

Father: _____

Mother: _____

Siblings:

_____

_____

_____

Others:

_____

Form Completed By: Date: