Broomfield Pediatrics Patient History Questionnaire

Name _____ M F Birth Date _____ Age _____ Date _____

Form Completed By _____ Biological parent of child? Yes No

If not biological parent, relationship to child:

Household

Please list all those living in the child's home

Name	Relationship to Child	Birth Date	Heath Problems

Birth History

Birth weight _____

Was the baby born at term? _____ Early? _____Late? _____

If early, how many weeks' gestation? _____

Did mother have any illness or problem with her pregnancy?

❑ Yes ❑ No Explain: _____

During pregnancy, did mother:

Smoke ❑ Yes ❑ No Drink Alcohol ❑ Yes ❑ No

Use drugs or medications ❑ Yes ❑ No

What: _____ When_____

Was the delivery ❑ Vaginal? ❑ Cesarean?

If cesarean, why?_____

Did your baby have any problems right after birth?

❑ Yes ❑ No Explain: _____

Was initial feeding ❑ Breast? ❑ Bottle?

Did your baby go home with mother from hospital?

❑ Yes ❑ No Explain: _____

General

Do you consider your child to be in good health?	❑ Yes	❑ No	Explain _____
Does your child have any serious illness or medical condition?	❑ Yes	❑ No	Explain _____
Has your child had serious injuries or accidents?	❑ Yes	❑ No	Explain _____
Has your child had any surgery?	❑ Yes	❑ No	Explain _____
Has your child ever been hospitalized?	❑ Yes	❑ No	Explain _____
Is your child allergic to any medicines of drugs?	❑ Yes	❑ No	Explain _____

Development

Are you concerned about your child's physical development?	❑ Yes	❑ No	Explain _____
Are you concerned about your child's mental or emotional development?	❑ Yes	❑ No	Explain _____
Are you concerned about your child's attention span?	❑ Yes	❑ No	Explain _____

If you child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

Family Situation

❑ Do you find time for yourself, for the other children, & your spouse? _____

❑ What do you do when things seem to be getting to you? _____

❑ Have you been in a relationship where you have been threatened or abused? _____

❑ What do you do for a living? _____

Family History

Have any family member had the following?

Deafness	❑ Yes ❑ No	Who _____	Comments _____	
Nasal Allergies	❑ Yes ❑ No	Who _____	Comments _____	
Asthma	❑ Yes ❑ No	Who _____	Comments _____	
Tuberculosis	❑ Yes ❑ No	Who _____	Comments _____	
Heart Disease (before 50 years old)	❑ Yes ❑ No	Who _____	Comments _____	
High blood pressure (before 50 years old old)	❑ Yes ❑ No	Who _____	Comments _____	
High cholesterol	❑ Yes ❑ No	Who _____	Comments _____	
Anemia	❑ Yes ❑ No	Who _____	Comments _____	
Bleeding Disorder	❑ Yes ❑ No	Who _____	Comments _____	
Liver Disease	❑ Yes ❑ No	Who _____	Comments _____	
Kidney disease	❑ Yes ❑ No	Who _____	Comments _____	
Diabetes (before 50 years old)	❑ Yes ❑ No	Who _____	Comments _____	
Bed-wetting (after 10 years old)	❑ Yes ❑ No	Who _____	Comments _____	
Epilepsy or convulsions	❑ Yes ❑ No	Who _____	Comments _____	
Alcohol abuse	❑ Yes ❑ No	Who _____	Comments _____	
Drug abuse	❑ Yes ❑ No	Who _____	Comments _____	
Mental Illness	❑ Yes ❑ No	Who _____	Comments _____	
Mental retardation	❑ Yes ❑ No	Who _____	Comments _____	
Immune problems, HIV, or AIDS	❑ Yes ❑ No	Who _____	Comments _____	

Additional family history: _____

Past History

Does your child have, or has he/she ever had:

Chicken pox	❑ Yes ❑ No	Explain: _____
Frequent ear infections	❑ Yes ❑ No	Explain: _____
Problems with ears or hearing	❑ Yes ❑ No	Explain: _____
Nasal allergies	❑ Yes ❑ No	Explain: _____
Problems with eyes or vision	❑ Yes ❑ No	Explain: _____
Asthma, bronchitis, bronchiolitis or pneumonia	❑ Yes ❑ No	Explain: _____
Any heart problem or heart murmur	❑ Yes ❑ No	Explain: _____
Anemia or bleeding problem	❑ Yes ❑ No	Explain: _____
Blood transfusion	❑ Yes ❑ No	Explain: _____
Frequent abdominal pain	❑ Yes ❑ No	Explain: _____
Constipation requiring doctor visits	❑ Yes ❑ No	Explain: _____
Bladder or Kidney infection	❑ Yes ❑ No	Explain: _____
Bed-wetting (after 5 years old)	❑ Yes ❑ No	Explain: _____
(for girls) Has she started her menstrual periods?	❑ Yes ❑ No	Explain: _____
(for girls) Are there problems with her periods?	❑ Yes ❑ No	Explain: _____
Any chronic or recurrent skin problem (acne, eczema etc.)	❑ Yes ❑ No	Explain: _____
Frequent headaches	❑ Yes ❑ No	Explain: _____
Convulsions or other neurologic problem	❑ Yes ❑ No	Explain: _____
Diabetes	❑ Yes ❑ No	Explain: _____
Thyroid or other endocrine problem	❑ Yes ❑ No	Explain: _____
Any other significant problems	❑ Yes ❑ No	Explain: _____
Use of alcohol or drugs	❑ Yes ❑ No	Explain: _____

Today's Date:_____

Clinician/Provider Signature _____