CREEKSIDE MEDICAL
specialists for adults, specialists for children

Pediatric Health Questionnaire

Date ______________________________

Please print, complete, and bring to your initial appointment.

Name:	Date of Birth:	M/ F (circle one)
Parent/ Guardian Name:	Phone:	
Who lives at home with you?		
Prior Physician:	Referred By:	

Family Medical History: Indicate health problems

MEMBER	AGE	HEALTH PROBLEMS
Mother		
Father		
Brother/Sister		
Brother/Sister		
Brother/ Sister		
Brother/ Sister		
Other		

IS THERE A FAMILY HISTORY OF:

☐ Diabetes	☐ High Blood Pressure	☐ Sickle Cell Anemia
☐ Migraines	☐ Asthma or Allergies	☐ Childhood Cancers
☐ Seizure Disorder	☐ Inherited or Genetic Diseases	☐ Cardiac/Heart Problems
☐ Bleeding Disorders	☐ Childhood Cancers	☐ Ulcerative Colitis or Crohn's Disease
☐ Leukemia	☐ Juvenile Arthritis	☐ Developmental or Psych Disorders

Other ______________________________

HAS THE PATIENT EVER HAD ANY OF THE FOLLOWING:

☐ Chicken Pox	☐ Heart Murmur	☐ Psychiatric Problem	☐ Cancer
☐ Asthma	☐ Irregular Pulse	☐ Seizure (epilepsy)	☐ Rheumatic Fever
☐ Pneumonia	☐ Diabetes	☐ Anemia (low blood count)	☐ Easy Bleeding
☐ Hepatitis	☐ High Blood Pressure	☐ Concussion	☐ Sickle Cell Anemia
☐ Eczema	☐ Fainting Spell	☐ Ulcer	☐ Blood Transfusion
☐ Serious Allergic Reaction		☐ Other ______________________________	

List all medications (specify amount and doses per day) including vitamins and over-the-counter:	
List any allergies to medications:	
Name of Drug(s):	Reaction it Causes:

Is the patient current on their immunizations? ☐ Yes ☐ No
If no, reason vaccines are not up to date ______________________
Medical History:
List any additional medical problems:
List any and all surgeries or hospitalizations with approximate dates:

PERINATAL HISTORY			
Number of pregnancies of mother:			
Did the mother have any of the following during pregnancy with this child:			
☐ Diabetes or sugar in urine	☐ Protein in Urine	☐ High Blood Pressure	☐ Bleeding
☐ Infection	☐ Preterm Labor	☐ Smoking	☐ Drug Use
☐ Drinking Alcohol	☐ Medications taken		
Was the child born within two weeks of the due date? ☐ Yes ☐ No			
☐ Vaginal Birth	☐ C-Section Reason for C-Section:______________________		
Did Child and Mother get discharged from hospital together? ______________________			
Birth Weight: ______________________			
Did the child have:			
☐ Breathing Problems	☐ Infection	☐ Jaundice	☐ Feeding Problems

Any other pertinent medical information pertaining to this visit: