Pediatric Health History Questionnaire

Patient Name: ____ DOB: _________________

Great healthcare is the result of great communication. At Mount Carmel Medical Group, we want to understand everything we can about your ideas on healthcare, your concerns, and your goals for your child. Keeping them well means knowing them well. Thank you for beginning our conversation before their visit by completing this information.

Main reason for today's visit:
____

Other concerns:
____

____

____

ALLERGIES

Please list all allergies (medications, food, bee stings, etc.) and reactions to each.

ALLERGY	REACTION
1.________________________	________________________
2.________________________	________________________
3.________________________	________________________
4.________________________	________________________

MEDICATIONS

Please list all the medications you are currently taking. Include prescribed drugs and over-the-counter drugs, as well as vitamins and supplements.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.________________	________________	________________
2.________________	________________	________________
3.________________	________________	________________
4.________________	________________	________________
5.________________	________________	________________
6.________________	________________	________________
7.________________	________________	________________
8.________________	________________	________________
9.________________	________________	________________
10.________________	________________	________________

IMMUNIZATION HISTORY

Immunizations and most recent date of administration:

Chickenpox	Date:_____________	Meningococcus	Date:_____________
Flu Shot	Date:_____________	MMR *(Measles, Mumps, Rubella)*	Date:_____________
Gardasil/HPV	Date:_____________	Pneumonia	Date:_____________
Hepatitis A	Date:_____________	Tdap *(Tetanus and pertussis)*	Date:_____________
Hepatitis B	Date:_____________	Tetanus	Date:_____________
		Zostavax *(Shingles)*	Date:_____________

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PAST MEDICAL HISTORY

Please list any past medical history:

____
____
____
____

PERINATAL HISTORY

PRENATAL HISTORY	BIRTH HISTORY	
☐ Abnormal Ultrasound ☐ Bleeding ☐ Gestational Diabetes ☐ Growth Delay ☐ Pregnancy Medications	Birth Hospital: ______________ Birth Weight: ______________ Breathing Problems: ______________ C-Section: ______________ Fetal Distress: ______________ Gestational Age: ______________	Intubation: ______________ Jaundice: ______________ Preterm Labor: ______________ VBAC Delivery: ______________ Vacuum: ______________ Vaginal Delivery: ______________

FAMILY HISTORY

Grandmother (maternal)	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Grandfather (maternal)	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Grandmother (paternal)	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Grandfather (paternal)	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Father	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Mother	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension

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Brother	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Sister	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension
Other	☐ Alcoholism ☐ Diabetes ☐ Osteoporosis	☐ Arthritis ☐ Genetic Disease ☐ Stroke	☐ Depression ☐ Heart Disease ☐ Other	☐ Cancer ☐ Hypertension

SOCIAL HISTORY

Diet	☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Specific Carbohydrate ☐ Cardiac ☐ Diabetic ☐ Breast Fed ☐ Formula Fed	**Parent's Marital Status**	☐ Married ☐ Unmarried ☐ Divorced ☐ Separated ☐ Widowed	Animal Exposure? ☐ Yes ☐ No Passive Smoke Exposure ☐ Yes ☐ No Smoke/CO detectors in home? ☐ Yes ☐ No Seatbelts used routinely? ☐ Yes ☐ No Car seat used routinely? ☐ Yes ☐ No Guns present in home? ☐ Yes ☐ No
Exercise Level	☐ None ☐ Occasional ☐ Moderate ☐ Heavy	**Caffeine**	☐ None ☐ Occasional ☐ Moderate ☐ Heavy	
Living Situation	☐ Both parents ☐ Mother ☐ Father ☐ Relatives ☐ Adoptive Parents ☐ Foster Parents ☐ Other	**Childcare**	☐ None ☐ Relatives ☐ Private Sitter ☐ Daycare/ Preschool	

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL

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Please add any additional health information here:

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____

____

____

____ ___________________

Parent, Guardian, or Caregiver Signature **Date**

____ ___________________

Provider Signature **Date**