PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

Age 0-13 years

Inkwell Medical Group

Name: _____ DOB: _____ Today's Date:_____

Maternal History:

Mother's age at delivery _____ Number of Pregnancies _____ Number of Deliveries _____

Blood Type _____ Length of Pregnancy _____ Vaginal or C section Delivery _____

Complications of pregnancy, labor & delivery, medications during pregnancy

_____

Child's problems at birth (if any):

_____

Birth History:

Birth Weight _____Lbs _____Oz. Breast or Bottle Fed? _____

APGAR Score _____/_____if known Child's Blood Type _____ Child's Sex Male/Female

WIC Yes/No

Medical History:

Hospitalizations/Surgeries:

_____

Chronic Health Problems:

_____

Medications: _____

Drug Allergies: _____

Family History: Name DOB Health Status Occupation

Mother _____

Father _____

Siblings Brother/Sisters:

_____

_____

Primary Caregiver if not parents:

_____

Does anyone in the family have any of the following? (Please circle)

Anemia Arthritis Bleeding Deafness Diabetes Kidney Disease Birth Defects

Thyroid Disease Asthma Hepatitis HIV Migraines Alcohol/Drug abuse Seizures

Heart Disease Hypertension Cancer Tuberculosis Retardation Emotional Problems Suicide

Social History: Pets_____ Smokers inside/Outside _____

What type of heating system do you have? Central-Wood-Electric-Gas-Other _____

What type of cooling/air conditioning system? Central-Window Air Conditioners-Fans-Other _____

Do you have city water or well water? _____ Who live in household? _____

Daycare or school attended _____

Hobbies/Activities/Sports _____Seatbelt/Car Seat _____