The following questions will help the doctor provide continuing care for your child. This will become a part of the child's permanent record.

Name of Patient _____ **Birth-date** _____ **Today's Date** _____

A. PREGNANCY AND BIRTH:

1. Did the baby come on time? ..... Yes No
2. Birth weight _____
3. Did the baby have any trouble while in the hospital? ..... Yes No
4. Did you take any medications during pregnancy? ..... Yes No

B. FAMILY HISTORY:

1. Circle any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers or sisters have had:

Seizures	Cancer	Inherited or Family Diseases	Kidney Trouble	Nervous Breakdown
Diabetes	Asthma	Tuberculosis (TB)	Heart Trouble	Other _____
Hay fever	Allergy	High Cholesterol	Sinus Trouble	_____

2. Are the child's parents in good health? ..... Yes No
3. List the names and ages of the child's brothers and sisters:

   _____ _____

   _____ _____
4. Age of parents: _____
5. Parent's Occupation: _____
6. Do any of the other children have any health problems? ..... Yes No
7. Have any of your children died? ..... Yes No

C. PREGNANCY AND BIRTH:

1. Did you have any illness during pregnancy? ..... Yes No
2. Did you take any medicine during pregnancy? ..... Yes No
3. Did anything happen during pregnancy that you are afraid might affect your baby? ..... Yes No
4. Have you ever lost a child? ..... Yes No

D. FEEDING AND DIGESTION:

1. Is or was your baby breast fed? ..... Yes No
2. Is or was your baby bottle fed? ..... Yes No
3. Have any of your previous children had feeding problems? ..... Yes No
4. Do you have any family history of food allergies? ..... Yes No

E. DEVELOPMENT: Did this child:

1. Roll over by age 6 months? ..... Yes No
2. Sit alone by age 9 months? ..... Yes No
3. Walk alone by age 15 months? ..... Yes No
4. Say any words by age 18 months? ..... Yes No

F. CURRENT MEDICATIONS: _____

_____

pinnacle MEDICAL GROUP, INC. **PEDIATRIC QUESTIONNAIRE** PT# _____

PEDIATRIC QUESTIONNARE, CONT.

G. HEALTH HISTORY: Has your child:

1. Had as many as three attacks of ear trouble? ..... Yes No
2. Had trouble with urination? ..... Yes No
3. Ever had a convulsion? ..... Yes No
4. Had any trouble with hearing? ..... Yes No
5. Had any trouble with vision? ..... Yes No
6. Dental Problems? ..... Yes No
7. Circle any of the following that your child has had: ..... Yes No

Chickenpox	Broken Bones	Serious Accidents	Removal of Tonsils & Adenoids
Roseola	Ear Tubes	Pneumonia	

Other Operations _____

Other Diseases _____

Other Hospitalizations - Age and for what? _____

_____

_____

H. ALLERGIES: Has your child ever had:

1. Eczema or hives? ..... Yes No
2. Wheezing or asthma? ..... Yes No
3. Allergies or reactions to any medicines or injections? ..... Yes No

I. BEHAVIOR: Does your child:

1. Get along well in school? ..... Yes No
2. Get along well with other children? ..... Yes No
3. Have any of the following problems: (Please circle)

Learning Problems	Speech Problems	Temper Tantrums
Bed Wetting	Breath Holding	

J. SOCIAL HISTORY: Who lives at home with the child? (Circle all that apply)

Birth Mother	Birth Father	Stepmother	Other _____
Adoptive Mother	Adoptive Father	Stepfather	

K. TESTS AND IMMUNIZATIONS:

1. Do you have a record of your child's shots? ..... Yes No
2. Has the child ever had a hearing test? ..... Yes No
3. Has the child ever had a vision test? ..... Yes No
4. Has the child seen a dentist in the past year? ..... Yes No
5. Has the child seen a doctor in the past year? ..... Yes No

Completed By: _____
Signature

Reviewed By: _____
Provider signature Date Time

PT Name: _____ PT# _____ PT DOB _____