BROWNSBORO PARK PEDIATRICS HEALTH QUESTIONAIRE

Please fill out for each child

Patient's Name_____ **Date of Birth** _____

MEDICATIONS: (List all medications/dosage for your child)

_____

_____

ALLERGIES:

___Drug Allergies (List all) _____ __Latex allergy

__Allergic Rhinitis __Asthma __ Urticaria (hives) __Eczema/Chronic dry skin __Food Intolerance

NEWBORN PERIOD

___Vaginal Delivery ___ C-Section ___Difficult Delivery
___Term ___ Pre-term ___ Birth Weight _____
___Jaundice ___ Phototherapy ___Heart or Lung Problems
___Feeding Problems ___Delayed Discharge Home from Nursery
___Other _____

FEEDING AND DIGESTION:

___ Breast fed ___Bottle Fed ___Poor Appetite
___Vomiting ___Chronic Loose Stools ___Constipation Issues
___ Other _____

INFECTIONS, DEVELOPMENT, MISC PROBLEMS:

___ Dental Problems ___Developmental Delays Eye Problems (Glasses, Etc.)
___Frequent Sore Throat ___Frequent Ear Infections ___Hearing Loss
___ Heart Problems ___Elevated Blood Pressure ___Seizures
___Pneumonia ___Pica (Eating Dirt, Plants, Etc.) ___Orthopedic Problems
___ Kidney or Bladder Infections __Bed wetting ___Down Syndrome
___ Other _____

SURGICAL PROCEDURES and HOSPITALIZATIONS:

___ Tonsillectomy, Adenoidectomy, and/or Ear Tubes ___Other Surgical Procedures
___Serious Injuries (Concussions, Broken Bones, Etc.) ___Hospitalizations_____

PSYCHOLOGICAL PROBLEMS:

___ADHD ___ Antisocial Behavior ___Drug Use/Abuse
___Anxiety ___Breath holding ___School Adjustment Problems
___Discipline Problems ___Tics/Nervous Habits ___Learning Disability
___Nightmares ___Temper Tantrums ___ Peer Relationships
___Speech Problems ___Poor School Performance
___Other_____

Parent Name and Age _____ **Parent Name and Age** _____

List all Children and Date of Birth

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

FAMILY SOCIAL HISTORY

Parents Marital Status:
___Single ___Married ___Divorced and who is custodial parent? _____

How many adults live in the household? _____ How many children live in the household? _____

FAMILY HISTORY: Please indicate **"M"** for maternal (Mother's side) and **"P"** for paternal (Father's side)

Disease	**Disease**
_____ Unknown/No Information	_____Heart Disease
_____ No Inheritable Medical Problems	_____Heartburn (GERD)
_____ Alcoholism/Drug Use	_____High Cholesterol
_____ Allergies	_____High Blood Pressure
_____ Asthma	_____Hyperthyroid (Over-Active Thyroid)
_____ Bleeding Disorder	_____Hypothyroid (Under-Active Thyroid)
_____ Cancer	_____Iron Deficiency/Anemia
_____ Cerebrovascular Disease (Stroke)	_____Kidney Disease
_____ Crohn's Disease	_____Lupus
_____ Depression/Anxiety	_____Mental Illness (Other than Depression/Anxiety)
_____ Diabetes	_____Rheumatoid Arthritis
_____ Eczema	_____Seizures
_____ Early Heart Attack (<Age 50)	_____Tuberculosis
_____ Hearing Loss	_____Ulcerative Colitis

List any other inherited health issues or serious health problems in either side of the family not listed above_____
_____
_____

Name of person completing this form_____Today's Date_____