village
PEDIATRICS

5425 West Spring Creek Pkwy
Suite 175
Plano Texas 75024

T 214 473 2200
F 214 473 2201

HISTORY QUESTIONNAIRE

Please complete all information as applicable to your child.

PATIENT NAME ______________________________ **BIRTH DATE** ______________

MEDICAL HISTORY

Birth: Was your child born on time? ❑ Yes ❑ No Any problems? ❑ Yes ❑ No ______________
Birth weight ______________
Major Illnesses? Please list ______________________________
Hospital Stays? ______________________________
Emergency Room Visits? ______________________________
Surgeries? ______________________________
Fractures or Injuries? ______________________________

If your child has a history of asthma, reactive airway disease, bronchiolitis, or wheezing:
First episode? ______________ Last episode? ______________
Any prevention meds? ______________ When was the last use of rescue meds? ______________
Do you have a home nebulizer? ❑ Yes ❑ No Do you use a spacer? ❑ Yes ❑ No
Do you have questions about treating your child's symptoms? ❑ Yes ❑ No
Any reactions/allergies to medicines or foods? ______________________________
Any reactions to immunizations? ______________________________

Please list any meds that your child is taking. Include prescription, OTC, homeopathic, vitamins, occasionally taken and daily ______________________________
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Are your child's immunizations up to date? ❑ Yes ❑ No ❑ UNSURE
Please attach a copy of his or her shot record.

SOCIAL HISTORY

Who lives in your home? ______________________________
Do you have smoke detectors/ carbon monoxide detectors? ❑ Yes ❑ No
Is your child in contact with cigarette smoke- in house, car, outdoors? ❑ Yes ❑ No
Has you family or child experienced any recent stressors or conflict? ❑ Yes ❑ No
Please describe ______________________________
How many hours of television or computer/video play does your child have per week? ______________
How many hours of sports/activities does your child have per week? ______________
Please describe ______________________________
Please tell us your child's school and grade ______________________________
Does your child attend daycare, home care, after school care? ______________________________
Any concerns with school progress, development, or social interactions? ❑ Yes ❑ No
Please explain ______________________________
Do you have questions about parenting or about your child's behavior? ❑ Yes ❑ No
Please explain ______________________________

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FAMILY HISTORY

Mother's height _______________ Father's height _______________

Below is a list of various health conditions. Please indicate any that affect your family (parents, siblings, grandparents, aunts/uncles of your child) and who has been affected.

- ❑ Allergies
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Birth Defects
- ❑ Bone/Muscle Disease
- ❑ Cancer
- ❑ Cerebral Palsy
- ❑ Cystic Fibrosis
- ❑ Diabetes- adult or child onset
- ❑ Drug/Alcohol Abuse
- ❑ Eczema
- ❑ Eye/Ear problems
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Kidney/Liver disease
- ❑ Learning Differences
- ❑ Mental Illness
- ❑ Metabolic/Genetic Disorder
- ❑ Sickle Cell Trait/Disease
- ❑ Seizures
- ❑ Stroke
- ❑ Sudden Death
- ❑ Tuberculosis
- ❑ Thyroid Problems

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REVIEW OF SYSTEMS

General

Any unusual or concerning weight gain or loss? ❑ Yes ❑ No

Recurring fevers? ❑ Yes ❑ No

Trouble growing? ❑ Yes ❑ No

Trouble sleeping? ❑ Yes ❑ No

Recent change to activity level? ❑ Yes ❑ No

Neurological

Headaches? ❑ Yes ❑ No

Seizures? ❑ Yes ❑ No

Concussions or been "knocked out", lost consciousness? ❑ Yes ❑ No

Dizziness? ❑ Yes ❑ No

Respiratory

Recurring cough? ❑ Yes ❑ No

H/O trouble breathing? ❑ Yes ❑ No

Cardiovascular

Palpitations? ❑ Yes ❑ No

Chest pain? ❑ Yes ❑ No

Fainting or almost fainting? ❑ Yes ❑ No

Trouble exercising? ❑ Yes ❑ No

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GI/ Nutrition

- Significant spitups or recurrent vomiting? ❑ Yes ❑ No
- Trouble with bowel movements- diarrhea, constipation? ❑ Yes ❑ No
- Recurring abdominal pain? ❑ Yes ❑ No
- Does your child have difficulty eating a variety of foods, food types (if applicable) ❑ Yes ❑ No
- Do you think your child eats too much or not enough? ❑ Yes ❑ No

Eye/Ear/Nose/Throat

- Concerns about your child's vision? ❑ Yes ❑ No
- Concerns about your child's hearing? ❑ Yes ❑ No
- Recurring infections? ❑ Yes ❑ No
- Allergies? ❑ Yes ❑ No

Skin

- Concerning lesions or rash? ❑ Yes ❑ No
- Birthmarks? ❑ Yes ❑ No
- Easy bruising? ❑ Yes ❑ No

Psychological/Behavioral/Developmental

- Does your child seem sad, angry, or anxious? ❑ Yes ❑ No
- Are you concerned about your child's self esteem? ❑ Yes ❑ No
- Problems with temper tantrums? ❑ Yes ❑ No
- Any trouble with toilet training? ❑ Yes ❑ No
- Do you think your child is developing normally? ❑ Yes ❑ No
- Are you concerned about your child's school performance or learning? ❑ Yes ❑ No

Do you have any other concerns about your child? Please explain.

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Thank you for your participation.