POTOMAC PHYSICIANS, P.A.

PEDIATRIC HEALTH QUESTIONNAIRE

Date: ______________________

FOR MACHINE IMPRINT: IF I.D. CARD NOT AVAILABLE, PRINT PATIENT'S NAME, DATE OF BIRTH, MEDICAL RECORD NUMBER, GROUP NUMBER AND MEMBER NUMBER.

DATE:

PLAN ____ MEMBER NUMBER __________

Name ______________________ DOB ______ S

Med. Rec. ______________________

Group ______________________

Ben ______________________

I. BIRTH HISTORY:

Date of Birth: ______________ Current Age: ______________ Weight at birth ______ lb ______ oz

Yes No

☐ ☐ Did this child's mother receive regular medical attention during this pregnancy?

☐ ☐ Was the pregnancy with this child full term? If "NO" explain: ______________________

List any drugs or medications which this child's mother used during this pregnancy: ______________________

☐ ☐ Is this child adopted?

Yes No

☐ ☐ Did this child's mother have any unusual problems during pregnancy (such as vaginal bleeding, kidney or bladder infection, high blood pressure, "toxemia", diabetes, convulsions, weight gain over 30 lbs., German measles, x-rays during first 3 months or other illnesses)? If "YES" explain: ______________________

☐ ☐ Was this a "planned" pregnancy?

☐ ☐ Did this child require photo therapy for Jaundice, oxygen, or other therapy in the nursery?

II. PAST MEDICAL HISTORY:

Yes No Has this child . . .

☐ ☐ . . . ever had an operation? If "YES" explain: ______________________

☐ ☐ . . . had any serious accidents or injuries? If "YES" explain: ______________________

☐ ☐ . . . ever had a bad or unusual (allergic) reaction to any foods or drugs? If "YES" explain: ______________________

Yes No Has this child . . .

☐ ☐ . . . ever been hospitalized? If "YES" explain: ______________________

☐ ☐ . . . ever received a blood transfusion? If "YES" explain: ______________________

Has this child ever had any of the following illnesses? If "YES" check and give date or age:

☐ Anemia (low blood count) ______________
☐ Asthma ______________
☐ Chicken Pox ______________
☐ German Measles ______________
☐ Measles ______________
☐ Mumps ______________
☐ Rheumatic Fever ______________
☐ Whooping Cough ______________
☐ Eczema ______________

Please list any other serious illnesses (give date or age) this child has had: ______________________

Please list all medications (both prescription and non-prescription drugs) which this child now uses regularly, or has used regularly in the past (include vitamins, laxatives, cold medicines, Tylenol, etc.): ______________________

Physician's Comments: ______________________

III. FAMILY HISTORY: Check relationship as indicated:

Relationship	Occupation	Date of Birth	Age at Death	Illnesses and / or Cause of Death
Mother				
Father				
Brothers / Sisters				

Has anyone in this child's family had any of the following problems? (Include aunts, uncles, grandparents, etc.):

Yes	No	
☐	☐	Alcoholism /Drug Addiction?
☐	☐	Allergy / Asthma?
☐	☐	Bleeding Problems?
☐	☐	Cancer / Tumor?
☐	☐	Deafness?
☐	☐	Diabetes (Sugar)?
☐	☐	Epilepsy (Fits, Seizures)?

Yes	No	
☐	☐	Heart Attack (Coronary)?
☐	☐	High Blood Pressure (Hypertension)?
☐	☐	Kidney Trouble?
☐	☐	Mental Retardation?
☐	☐	Nervous disorder?
☐	☐	Sickle Cell Anemia?
☐	☐	Suicide?
☐	☐	Tuberculosis?

Please list any other illnesses which run in this child's family: ______________________________

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Physician's Comments: ______________________________

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Please list other people living in the household with this child (other than those listed above):

Name	Age	Relationship

IV. IMMUNIZATION HISTORY:

Please list dates or approximate ages at which this child received the following immunizations:

DPT 1.______ 2.______ 3.______ 4.______ 5.______ Polio 1.______ 2.______ 3.______ 4.______ 5.______

Measles______ Mumps______ Rubella______ Tine (TB skin test)______ Result of TB test?______

V. GROWTH AND DEVELOPMENT

Yes	No	
☐	☐	Are you concerned about this child's height or weight?
☐	☐	Are there any problems with this child at home or school?
☐	☐	Does your child wear approved auto safety restraints?

Yes	No	
☐	☐	Are you concerned about this child's mental or emotional development?
☐	☐	Does this child have unusual difficulty getting along with others?

Physician's Comments: ______________________________

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VI. REVIEW OF SYSTEMS

Yes	No	Has this child . . .
☐	☐	. . . had significant health problems during the past year?
☐	☐	. . . had any unexplained weight loss or fail to gain weight?
☐	☐	. . . had vision problems or difficulty recognizing colors?
☐	☐	. . . had speech, hearing, ear or throat problems?
☐	☐	. . . had frequent colds or runny noses?
☐	☐	. . . had any unusual lumps or swollen glands?
☐	☐	. . . had a convulsion, seizure, or fit?

Yes	No	
☐	☐	. . . had a heart murmur or heart problems?
☐	☐	. . . had wheezing or difficulty breathing, or any other respiratory problems?
☐	☐	. . . had frequent stomach aches, abdominal pain, vomiting, or digestive problems?
☐	☐	. . . had frequent constipation, or diarrhea?
☐	☐	. . . had a bladder, kidney, or urine infection, bed wetting or any other urinary problems?
☐	☐	. . . had painful or swollen joints?
☐	☐	. . . had foot problems?
☐	☐	. . . had unusual bruising or bleeding?

For adolescent GIRLS only:

Yes	No	Has this child . . .
☐	☐	any unusual vaginal odor or discharge?
☐	☐	does she understand reproduction and contraception?
☐	☐	had any problems related to puberty?

Yes	No	Has this child . . .
☐	☐	started having menstrual periods? If "YES" at what age did periods begin? ________
☐	☐	any menstrual problems?
☐	☐	does she know breast self-examination?

Please list any additional problems or special concerns about this child's health which you would like to discuss: ____________

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For adolescent BOYS only:

Yes	No	Has this child . . .
☐	☐	had any problems related to puberty?

Please list any additional problems or special concerns about this child's health which you would like to discuss: ____________

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Physician's Comments: ____

Date:______________________ Age:________ Height:________ Weight:________ HC:________

Temp:________ RR:________ B.P.:________

*Circle if abnormal: ✓ if normal; underline if not done; describe all abnormal and/or additional findings:

GENERAL APPEARANCE Comments:	SKIN Comments:
LYMPHATICS Comments:	HEAD Comments:
EYES Comments:	EARS Comments:
NOSE Comments:	ORAL CAVITY Comments:
NECK Comments:	CHEST & LUNGS Comments:
ABDOMEN Comments:	RECTUM Comments:
GENITALIA (Male) Comments:	GENITALIA (Female) Comments:
NEUROLOGICAL Comments:	CARDIO-VASCULAR Comments:
MUSCULO-SKELETAL Comments:	PSYCHO-SOCIAL Comments:
VISUAL EXAM Comments:	HEARING TEST Comments:

Drawings:

Assessment:

1.

2.

3.

4.

Plan:

Physician's Signature______________________ **Date**________