FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Pediatric Health History Questionnaire

Patient's Name_____ Date of Birth:_____/_____/_____

Parent/Guardian Names: _____

Pregnancy and Birth History	
Mother's age at birth:	Father's age at birth:
Did mother have any of the following during pregnancy?	
☐ Fever or rash	☐ Tobacco use (how much)
☐ Group B strep	☐ Alcohol use (how much)
☐ Sugar in urine / diabetes	☐ Street drug use (what type)
☐ High blood pressure	☐ Medication use -Prescription or over-the-counter (list on page 2)
☐ Anemia	
☐ Infections -If yes what type and how were they treated:	

Newborn History		
Birth Weight:	Birth length:	Head Circumference:
Born on time? ☐ Early ☐ Late	How much:	
Type of delivery ☐ Vaginal ☐ C-section (why):		
How old was baby when she/he left the hospital?		
During the first week of life did the patient have any of the following:		
☐ Feeding trouble	☐ Seizures	☐ Fever
☐ Excess vomiting	☐ Breathing trouble	☐ Receive antibiotics
☐ Jaundice (yellow skin)	☐ Need of oxygen	☐ Diarrhea
☐ Cyanosis (blueness)	☐ Blood transfusion	☐ In intensive care unit

Medical History		
Where has child gone for check-ups previously:		
Date of last medical checkup:		
Date of last dental check-up:		
Is your child up-to-date on immunizations? ☐ Yes ☐ No	Please supply immunization records.	
Female Patients: Age periods started_____	Menstrual Flow: ☐ Reg. ☐ Irreg. ☐ Pain/Cramps	
Has your child had any of the following:		
☐ Chicken pox	☐ Wears glasses	☐ Asthma
☐ Measles	☐ Heart murmur	☐ Allergies
☐ Mumps	☐ Kidney or bladder infection	☐ Broken bones
☐ Frequent ear infections (>4 year)	☐ Bed wetting (>5 years old)	☐ Head injury
☐ Frequent throat infections (>4 year)	☐ Diabetes	☐ Seizures
Has your child ever been hospitalized or had surgery? ☐ Yes ☐ No If yes, list age and reason:		
Do you have any concerns about your child's development? ☐ Yes ☐ No If yes, please describe:		

Special Communication Needs		If "yes" to any questions below, how can we assist?
Visual impairment	☐ Yes ☐ No	
Hearing impairment	☐ Yes ☐ No	
Speech impairment	☐ Yes ☐ No	
Cognitive impairment	☐ Yes ☐ No	
Sensory impairment	☐ Yes ☐ No	
Language Preference:		

Family History

Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			

Have any of the child's relatives had the following conditions:

Condition	Relative		Condition	Relative
☐ Diabetes			☐ Kidney problems	
☐ Cancer			☐ Heart disease	
☐ Seizures			☐ Skin problems	
☐ Allergies/asthma			☐ Anemia	
☐ Bleeding problems			☐ HIV	
☐ High blood pressure			☐ Chemical dependency	
☐ Mental illness			☐ Other:	

Are there any religious or cultural factors that you would like us to take into account when planning your child's healthcare?

Allergies- Please list any allergies to medications or foods

Name	Symptom/Reaction	Name	Symptom/Reaction

Medications

Please list any medications that your child takes including over the counter medications, herbs, and supplements.

Name	Dose	Frequency	Name	Dose	Frequency

Specialty Providers:

In order that we can best coordinate your child's care, please list any medical providers they see outside of this practice

Name:_____ Phone:_____Last Seen:	Name:_____ Phone:_____Last Seen:
Name:_____ Phone:_____Last Seen:_____	Name:_____ Phone:_____Last Seen: _____

Parent/Guardian Signature:_____Date: _____/_____/_____