Patient Name:_____ Today's Date _____

Cypress Physicians Association
Pediatric Medical Questionnaire – BIRTH TO AGE 5

Date of Birth:_____Previous medical care – Dr. _____ Last Well Exam: _____

Reason for today's visit	**Date Began**
1.	
2.	
3.	

Pregnancy/Birth history
Any illnesses during pregnancy? Medication during pregnancy?
☐Smoking ☐ Alcohol ☐Drugs – during pregnancy? if yes what
At birth, how many gestational weeks was your child (term = 40 weeks)?
Type of delivery? Vaginal Birth weight: Birth length:
Single pregnancy Multiple (twin/triplet/etc) Complications?
Did baby receive the Hepatitis B vaccine in the hospital? Yes

Past Medical History:
Immunizations up to date? Yes – Please have your shot record available
Hospitalizations (when-where-why)
Serious injuries or ER visit (when-what)

Please check if your child has had problems below.							
Asthma/Wheezing	☐	Thyroid problems	☐	Diabetes	☐	Joint problems	☐
Pneumonia	☐	Headaches	☐	Jaundice	☐	Urinary infections	☐
Heart problems	☐	Seizures	☐	Reflux	☐	Hearing problems	☐
Heart murmur	☐	Bleeding tendency	☐	Eczema	☐	Vision problems	☐
Learning disability	☐	Blood transfusion	☐	Skin infections	☐	Other:	☐
ADHD/ADD	☐	Anemia	☐	Ear infections	☐		☐
Developmental delay	☐	Allergies/hayfever	☐	Cancer	☐		

Past Surgical History: (please indicate year)				
Appendix		Bone surgery		Ear tubes
Tonsils/Adenoid		Circumcision		Other:

Medications: list all prescription and over-the-counter medications or supplements			
Name	Dosage	Frequency	Indications/Use

Allergies to Medication/Food/Other?

Patient Name:_____ Today's Date _____

Pediatric Medical Questionnaire – BIRTH TO AGE 5 (page 2)

Family Medical History *list all blood relatives of your child who have these problems – use abbreviations (F) father, (M) mother, (MM) mother's mother, (MF) mother's father,(FM) father's mother, (FF) father's father, (B) brother, (S) sister,(C) cousin*					
Anemia		High blood pressure		Seizures	
Asthma		High cholesterol		Mental retardation	
Allergies		Diabetes		Cancer	
Heart disease		Tuberculosis		Sudden infant death	
Arthritis		Birth defects		Thyroid problems	
Migraines		Psychiatric illness		Other:	

Social History			
	First and Last Name	Age	Occupation
Mother			
Father			
Siblings	(First name/age/sex)		
Child care: ☐Home ☐Daycare ☐Nanny ☐Family members ☐Other			
At home are there ☐Smokers ☐Pets ☐Guns ☐Swimming pool ☐Smoke detectors ☐Fire extinguishers?			

Feeding and Nutrition
Current nutrition: ☐Breastfeeding ☐Formula ☐Table Food Cow Milk ☐Whole ☐2% ☐1% ☐skim
If breastfeeding, how much/often?
If formula, what brand? Amount? _____ oz every ___ hours
If regular milk, which type ☐whole ☐2% ☐1% ☐skim Amount per day? oz
Is your child receiving vitamins?

Developmental History
At what age did your child sit alone? _____ Walk alone? _____
Did your child say any words by 15 months old?
At what age was your child potty trained during the day?
Compared to other children his/her age, is your child ☐advanced ☐same ☐behind

REVIEW OF SYSTEMS: Select if your child currently has any of the following:			
☐ Fever	☐ Thrush	☐ Diaper rash	☐ Itching
☐ Weight loss	☐ Sore throat	☐ Pain with urination	☐ Jaundice/yellow skin
☐ Vision problems	☐ Cough	☐ Blood in urine	☐ Rash
☐ Red/pink eye	☐ Turning blue	☐ Scrotal swelling	☐ Fainting
☐ Eye drainage	☐ Stop breathing	☐ Vaginal discharge	☐ Headaches
☐ Hearing problems	☐ Wheezing	☐ Joint pain	☐ Seizures
☐ Ear drainage	☐ Constipation	☐ Problems walking	☐ Swollen glands
☐ Nasal congestion	☐ Diarrhea	☐ Birthmark	☐ Behavior problems
☐ Runny nose	☐ Vomiting	☐ Easy bruising	☐ Snoring
☐ Allergies/sneezing	☐ Food intolerances	☐ Easy bleeding	☐

OFFICE USE ONLY:

Wt	**Ht**	**HC**
HR	**T**	**O2**