

Patient Name: _____ Today's Date _____

**Cypress Physicians Association
Pediatric Medical Questionnaire – OVER AGE 5**

Date of Birth: _____ Previous medical care – Dr. _____ Last Well Exam: _____
 Last Vision Exam: _____ Last Dental Exam: _____

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

Past Medical History:
Immunizations up to date? Yes No Unsure – Please have your shot record available
Hospitalizations (when-where-why)
Serious injuries or ER visits (when-what)

<i>Please mark (X) if your child has had problems below.</i>							
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/hay fever		Cancer			

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

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

Allergies to Medication/Food/Other?

Developmental History
Did your child have any developmental problems?
Compared to other children his/her age, is your child advanced same behind
Problems with bedwetting tantrums hyperactivity speech learning difficulties
For Females: Age at first menstrual period _____ Last menstrual period _____

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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)		
School Name/Grade:	Has your child repeated any school years?		
Extracurricular activities or sports:			
At home are there Smokers Pets Guns Swimming pool Smoke detectors Fire extinguishers?			

Feeding and Nutrition

How many servings does your child receive per day? Meat ___ Dairy ___ Bread ___ Fruits/Vegetables ___
Is your child receiving vitamins?
How much milk does your child drink? _____oz per day Whole/2%/1%/skim?

REVIEW OF SYSTEMS: Mark (x) if your child currently has any of the following:

<input type="checkbox"/>	Fever	<input type="checkbox"/>	Nasal congestion	<input type="checkbox"/>	Pain with urination	<input type="checkbox"/>	Itching
<input type="checkbox"/>	Weight loss	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	Acne
<input type="checkbox"/>	Abnormal weight gain	<input type="checkbox"/>	Cough	<input type="checkbox"/>	Scrotal swelling	<input type="checkbox"/>	Rash
<input type="checkbox"/>	Vision problems	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	Breast pain	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	Red/pink eye	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Menstrual cramps	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Eye drainage	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Vaginal discharge	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Hearing problems	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	Swollen glands
<input type="checkbox"/>	Ear drainage	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	Behavior problems
<input type="checkbox"/>	Ear pain	<input type="checkbox"/>	Stomach pain	<input type="checkbox"/>	Easy bleeding	<input type="checkbox"/>	Snoring
<input type="checkbox"/>	Runny nose	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Irregular periods	<input type="checkbox"/>	Allergies/sneezing

Any other concerns?

OFFICE USE ONLY:

Wt	Ht	BP
HR	T	O2