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 (if applicable)**

Pregnancy/Birth history
Any illnesses during pregnancy? Medication during pregnancy?
Smoking Alcohol Drugs – during pregnancy?
At birth, how many gestational weeks was your child (full term = 40 weeks)?
Type of delivery? Vaginal C-section Birth weight: Birth length:
Single pregnancy Multiple (twin/triplet/etc) Any Complications?
Did baby receive the Hepatitis B vaccine in the hospital? Yes No Not sure

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

Please mark (X) 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		Sleep problems	
ADHD/ADD		Anemia		Ear infections		Other:	
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 (PLEASE DESCRIBE REACTION – i.e. rash, nausea, etc)
Pharmacy (location/phone):

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, (MGM) mother's mother, (MGF) mother's father,(PGM) father's mother, (PGF) 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	Lives with child?
Mother				Yes No
Father				Yes No
Siblings	(First name/age/sex)			
Other people living in household:				
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, circle 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: Mark (x) 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**

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**

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)

Please mark (X) 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		Sleep problems	
ADHD/ADD		Anemia		Ear infections		Other:	
Developmental delay		Allergies/hay fever		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?

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 _____

Patient Name:_____ Today's Date _____

Pediatric Medical Questionnaire – OVER AGE 5 (page 2)

Family Medical History *list all blood relatives of your child who have these problems – use abbreviations (F) father, (M) mother, (MGM) mother's mother, (MGF) mother's father,(PGM) father's mother, (PGF) 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	Lives with patient?
Mother				Yes No
Father				Yes No
Siblings	(name/age/sex)			
Other people living in household:				
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:							
	Fever		Nasal congestion		Pain with urination		Itching
	Weight loss		Sore throat		Blood in urine		Acne
	Abnormal weight gain		Cough		Scrotal swelling		Rash
	Vision problems		Difficulty breathing		Breast pain		Fainting
	Red/pink eye		Wheezing		Menstrual cramps		Headaches
	Eye drainage		Constipation		Vaginal discharge		Seizures
	Hearing problems		Diarrhea		Joint pain		Swollen glands
	Ear drainage		Vomiting		Easy bruising		Behavior problems
	Ear pain		Stomach pain		Easy bleeding		Snoring
	Runny nose		Nausea		Irregular periods		Allergies/sneezing

Any other concerns?

OFFICE USE ONLY:

Wt	**Ht**	**BP**
HR	**T**	**O2**