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 – 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	☐	Other:	☐
ADHD/ADD	☐	Anemia	☐	Ear infections	☐		☐
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, (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:			
☐ 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**