# Broomfield Pediatrics Patient History Questionnaire

Name ______________________ M F Birth Date __________ Age _______ Date ____________

Form Completed By ______________________ Biological parent of child? Yes No

If not biological parent, relationship to child:

## Household

Please list all those living in the child's home

| Name | Relationship to Child | Birth Date | Heath Problems |
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## Birth History

Birth weight ______________________

Was the baby born at term? _____ Early? _____Late? _____

If early, how many weeks' gestation? __________________

Did mother have any illness or problem with her pregnancy?

❑ Yes ❑ No Explain: ____________________________

During pregnancy, did mother:

Smoke ❑ Yes ❑ No Drink Alcohol ❑ Yes ❑ No

Use drugs or medications ❑ Yes ❑ No

What: __________________ When____________________

Was the delivery ❑ Vaginal? ❑ Cesarean?

If cesarean, why?____________________________________

Did your baby have any problems right after birth?

❑ Yes ❑ No Explain: ____________________________

Was initial feeding ❑ Breast? ❑ Bottle?

Did your baby go home with mother from hospital?

❑ Yes ❑ No Explain: ____________________________

## General

Do you consider your child to be in good health? ❑ Yes ❑ No Explain ____________________

Does your child have any serious illness or medical condition? ❑ Yes ❑ No Explain ____________________

Has your child had serious injuries or accidents? ❑ Yes ❑ No Explain ____________________

Has your child had any surgery? ❑ Yes ❑ No Explain ____________________

Has your child ever been hospitalized? ❑ Yes ❑ No Explain ____________________

Is your child allergic to any medicines of drugs? ❑ Yes ❑ No Explain ____________________

## Development

Are you concerned about your child's physical development? ❑ Yes ❑ No Explain ____________________

Are you concerned about your child's mental or emotional development? ❑ Yes ❑ No Explain ____________________

Are you concerned about your child's attention span? ❑ Yes ❑ No Explain ____________________

If you child is in school:

How is his/her behavior in school? ____________________

Has he/she failed or repeated a grade in school? ____________________

How is he/she doing in academic subjects? ____________________

Is he/she in special or resource classes? ____________________

## Family Situation

❑ Do you find time for yourself, for the other children, & your spouse? ____________________

❑ What do you do when things seem to be getting to you? ____________________

❑ Have you been in a relationship where you have been threatened or abused? ____________________

❑ What do you do for a living? ____________________

## Family History

Have any family member had the following?

Deafness ❑ Yes ❑ No Who ________________ Comments ________________
Nasal Allergies ❑ Yes ❑ No Who ________________ Comments ________________
Asthma ❑ Yes ❑ No Who ________________ Comments ________________
Tuberculosis ❑ Yes ❑ No Who ________________ Comments ________________
Heart Disease (before 50 years old) ❑ Yes ❑ No Who ________________ Comments ________________
High blood pressure (before 50 years old old) ❑ Yes ❑ No Who ________________ Comments ________________
High cholesterol ❑ Yes ❑ No Who ________________ Comments ________________
Anemia ❑ Yes ❑ No Who ________________ Comments ________________
Bleeding Disorder ❑ Yes ❑ No Who ________________ Comments ________________
Liver Disease ❑ Yes ❑ No Who ________________ Comments ________________
Kidney disease ❑ Yes ❑ No Who ________________ Comments ________________
Diabetes (before 50 years old) ❑ Yes ❑ No Who ________________ Comments ________________
Bed-wetting (after 10 years old) ❑ Yes ❑ No Who ________________ Comments ________________
Epilepsy or convulsions ❑ Yes ❑ No Who ________________ Comments ________________
Alcohol abuse ❑ Yes ❑ No Who ________________ Comments ________________
Drug abuse ❑ Yes ❑ No Who ________________ Comments ________________
Mental Illness ❑ Yes ❑ No Who ________________ Comments ________________
Mental retardation ❑ Yes ❑ No Who ________________ Comments ________________
Immune problems, HIV, or AIDS ❑ Yes ❑ No Who ________________ Comments ________________

Additional family history: ________________________________________

________________________________________________________________

________________________________________________________________

## Past History

Does your child have, or has he/she ever had:

Chicken pox ❑ Yes ❑ No Explain: ________________
Frequent ear infections ❑ Yes ❑ No Explain: ________________
Problems with ears or hearing ❑ Yes ❑ No Explain: ________________
Nasal allergies ❑ Yes ❑ No Explain: ________________
Problems with eyes or vision ❑ Yes ❑ No Explain: ________________
Asthma, bronchitis, bronchiolitis or pneumonia ❑ Yes ❑ No Explain: ________________
Any heart problem or heart murmur ❑ Yes ❑ No Explain: ________________
Anemia or bleeding problem ❑ Yes ❑ No Explain: ________________
Blood transfusion ❑ Yes ❑ No Explain: ________________
Frequent abdominal pain ❑ Yes ❑ No Explain: ________________
Constipation requiring doctor visits ❑ Yes ❑ No Explain: ________________
Bladder or Kidney infection ❑ Yes ❑ No Explain: ________________
Bed-wetting (after 5 years old) ❑ Yes ❑ No Explain: ________________
(for girls) Has she started her menstrual periods? ❑ Yes ❑ No Explain: ________________
(for girls) Are there problems with her periods? ❑ Yes ❑ No Explain: ________________
Any chronic or recurrent skin problem
(acne, eczema etc.) ❑ Yes ❑ No Explain: ________________
Frequent headaches ❑ Yes ❑ No Explain: ________________
Convulsions or other neurologic problem ❑ Yes ❑ No Explain: ________________
Diabetes ❑ Yes ❑ No Explain: ________________
Thyroid or other endocrine problem ❑ Yes ❑ No Explain: ________________
Any other significant problems ❑ Yes ❑ No Explain: ________________
Use of alcohol or drugs ❑ Yes ❑ No Explain: ________________

Today's Date: ________________________________