MRN _____ CSN _____

PEDIATRIC HISTORY QUESTIONNAIRE

5 to 17 years old

Child's Full Name (Last, First, M.I.): ❑ M ❑ F		**Age:**
Name child prefers to be called:	**Date of Birth:**	
Previous doctor:	**Last time child was at the doctor's:**	
Why is your child seeing the doctor today?		

HEALTH HISTORY
Has your child had shots? ❑ No ❑ Yes ❑ I don't know
Where were the shots given?
Do you know if the child is up to date on shots? ❑ No ❑ Yes ❑ I don't know

Is your child allergic to anything (medicine, foods, pollens, etc): ❑ No ❑ Yes
If yes, what is it and what happens?

List the times when your child was in the hospital, had surgery or any serious injuries:

Month/Year	Reason	Hospital

Has your child had any of the following problems:

❑ Chicken pox	❑ Measles	❑ Mumps	❑ Scarlet fever	❑ Rheumatic Fever	❑ Rubella (German measles)
❑ Chronic ear infections	❑ Asthma	❑ Eczema	❑ Lead Poisoning	❑ Burns	❑ Heart Murmur
❑ Heart problem	❑ Dehydration	❑ Reflux	❑ Anemia	❑ Seizure	❑ Urinary Tract Infection
❑ Allergies	❑ High blood pressure	❑ Diabetes	❑ Bike accident	❑ Foster care at any time	❑ Car accident
❑ Has been to Juvenile Court	❑ Physically, verbally, or sexually abused	❑	❑	❑	❑
Any others not listed:					

List all medicines your child is taking (including prescribed drugs and over-the-counter drugs, such as vitamins, inhalers, cough medicines, Tylenol, ibuprofen, etc)

Name the Drug	How often it is given	Name the drug	How often it is given
1.		2.	
3.		4.	
5.		6.	

Please turn to the next page

Signature of person filling out his form _____ Date _____ Relationship to Child _____

MRN _____ CSN _____

What medical problems are in the child's family? (both mother's and father's side, also siblings)	

SOCIAL HISTORY

Who does the child live with?	❑ Both Parents				
	❑ One parent who? ❑ Mother ❑ Father				
	❑ Step Parent				
	❑ Relatives/Friends who?:				
	❑ Foster Parent				
Home	**Are there any smokers in the home?** ❑ Yes ❑ No				
	What **pets** are in the home?				
	What is your neighborhood like?				
Family Stressors	❑ Marriage problems	❑ Money problems	❑ Legal problems	❑ Discipline problems	
	❑ Insurance problems	❑ Alcohol	❑ Drugs	❑ Abuse	
School	**Does your child go to school?** ❑ Yes ❑ No				
	If yes, what is the name of the School?				
	What level in school is the child?				
	What are their grades like?				
	Any problems in school? ❑ Yes ❑ No				
Does your child have problems with any of these?	❑ Anger	❑ Violent	❑ Skipping school	❑ ADHD	❑ Temper tantrums
	❑ Sleeping	❑ Eating	❑ Habits	❑ Fear	❑ Anxiety
	❑ Weird movements	❑ Bedwetting	❑ Biting	❑ Hitting	❑ Potty training
Diet	**Does your child eat 3 meals a day?** ❑ Yes ❑ No				
	How many **vegetables** does your child eat in one day? ❑ 1 ❑ 2-3 ❑ 4-5 ❑ 6				
	How many **fruits** do they eat in one day? ❑ 1 ❑ 2-3 ❑ 4-5 ❑ 6				
	How many times a week does this child eat **fast food**? ❑1 ❑2-3 ❑4-5 ❑6-7 ❑8-9 ❑greater than 10				
	What does your child **drink**? ❑Water ❑Juice ❑Coffee ❑Soda ❑Energy Drinks ❑Milk ❑Kool-aid				

Exercise and Activities	**Does your child play sports?** ❑ Yes ❑ No If yes, what sports?
	What are your child's favorite activities?
	Does your child play outside?
	Does your child watch TV? ❑ Yes ❑ No
	If yes, how many hours a day? ❑ 1 hour ❑ 2-3 hours ❑ 4-5 hours ❑ more than 6 hours
	Does your child play video games? ❑ Yes ❑ No
	If yes, how many hours a day? ❑ 1 hour ❑ 2-3 hours ❑ 4-5 hours ❑ more than 6 hours
	What time does your child go to bed? ❑ before 8 pm ❑ 9-10pm ❑ 11pm-12am ❑ after 1am
	When does your child wake up? ❑ before 5am ❑ 6-7am ❑ 8-9am ❑ 10-11am ❑ after 12pm

Signature of person filling out his form _____ Date _____ Relationship to Child _____

MRN _____ CSN _____

Other	**Does your child smoke?** ❑ Yes ❑ No
	Does your child drink alcohol? ❑ Yes ❑ No
	Has your child tried drugs (marijuana, meth, K2 bath salts, cocaine, pills, etc)? ❑ Yes ❑ No
	Is your child sexually active? ❑ Yes ❑ No
	If yes, have they ever been screened for STDs? ❑ Yes ❑ No
	How does your child interact with friends? ❑ Great, no problems ❑ OK, sometimes they fight ❑Not so good, fight often ❑ Bad ❑ My child doesn't have any friends
	How does your child interact with parents? ❑ Great, no problems ❑ OK, sometimes they fight ❑Not so good, fight often ❑ Bad ❑My child doesn't have parents
	Is your child bullied? ❑ Yes ❑ No
	Does your child bully other children? ❑ Yes ❑ No
	Has your child been to Cross Pointe, another psychiatry facility or Juvenile detention center? ❑ Yes ❑ No
	If yes, where and when?

OTHER PROBLEMS

Check if your child has had problems have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

❑ Skin	❑ Eyes	❑ Ears	❑ Nose	❑ Throat	❑ Teeth	❑ Lungs	❑ Heart	❑Stomach/Intestines
❑ Kidneys	❑ Bladder	❑ Bones	❑ Muscles	❑ Joints	❑ Blood	❑ Brain		

List any additional information you feel would be helpful for your doctor to know

Signature of person filling out his form _____ Date _____ Relationship to Child _____