OLYMPIA PEDIATRICS, PLLC.

HEALTH QUESTIONNAIRE

Patient Name _____ Date of Birth _____
Birth hospital/location_____

Dear Parent: Please fill out this questionnaire to give us a more complete record of your child. Skip any questions you can't answer or that do not apply. Thank You.

PREGNANCY AND BIRTH

Birth weight _____ lbs. _____oz. ☐ Born at term OR ☐ Born premature (<37 weeks) at _____weeks

Was the delivery ☐ Vaginal OR ☐ C-Section If C-Section, explain _____

_____

Any problems with the pregnancy, labor or delivery? ☐ Yes ☐ No If yes, explain_____

_____

Was the baby breech at any point during the third trimester or at birth? ☐ Yes ☐ No

Was a NICU stay required? ☐ Yes ☐ No If yes, explain _____

_____

During pregnancy, did the mother: ☐ Use tobacco ☐ Use drugs or medications
☐ Drink Alcohol ☐ Take prenatal vitamins

Did your baby go home with mother from the hospital? ☐ Yes ☐ No If No, please explain _____

_____

Was initial feeding: ☐ Formula ☐ Breast Milk How long breastfed? _____

PAST MEDICAL HISTORY

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No If yes, explain_____

_____

Has your child ever been hospitalized overnight? ☐ Yes ☐ No If yes, explain _____

_____

Has your child had any surgery? ☐ Yes ☐ No If yes, explain _____

_____

Does your child have any allergies to medications or foods? ☐ Yes ☐ No If yes, explain _____

_____

Does your child have, or has your child ever had any of the following:

- ☐ Eye conditions/corrective lenses
- ☐ Frequent ear infections
- ☐ Problems with ears or hearing
- ☐ Allergic rhinitis/nasal allergies
- ☐ Frequent sinusitis
- ☐ Asthma
- ☐ Other respiratory/lung problems
- ☐ Heart problems/murmurs
- ☐ Constipation requiring doctor visits
- ☐ Bed-wetting (after 5 years old)
- ☐ Recurrent urinary tract infections
- ☐ Frequent Headaches
- ☐ Seizures, convulsions, or other neurological problems
- ☐ Fractures
- ☐ Developmental delays
- ☐ ADHD/Anxiety/Mood problems/Depression
- ☐ Use of alcohol, tobacco, drugs
- ☐ Chronic or recurrent skin problems (eg. acne, eczema)
- ☐ Autoimmune or other immune problems
- ☐ Obesity
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Genetic/Metabolic disorder
- ☐ Anemia or other blood problems
- ☐ Cancer/chemotherapy
- ☐ Arthritis/Rheumatologic disorder
- ☐ Delayed or missing immunizations
- ☐ (For Girls) Problems with periods
  - ☐ Has had first period at _____ age

Any other significant problems

_____

_____

_____

(TURN OVER)

SOCIAL

Please list all those living in the child's home:

Name	Relationship to Child	Birthdate	Health Problems

What is the child's living situation if NOT with both biological parents?

☐ Joint custody ☐ Single Custody

☐ Lives with adoptive parents

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

_____

_____

FAMILY HISTORY

Please check which biological relative has any of the conditions listed below:

	Mother	Father	Sibling	Maternal Gma	Maternal Gpa	Paternal Gma	Paternal Gpa	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle
ADD/ADHD											
Allergies/Hay Fever											
Asthma											
Autism/ Developmental/ Learning Disorders											
Bedwetting											
Birth Defects											
Cancer											
Childhood Hip Problems											
Depression											
Diabetes											
Early Deaths											
Heart Attack Before Age 50											
High Cholesterol											
High Blood Pressure											
Other Heart Problems											
Seizures											
Strokes											
Substance Abuse											
Thyroid Problems											
Tuberculosis											

How did you find out about our office? ☐ Friends/Family ☐ Facebook ☐ Google/Website ☐ Other _____

Thank you!

_____ _____

Parent/Guardian Signature Date