North Olympic Healthcare NETWORK

NORTH OLYMPIC HEALTHCAR NETWORK
PEDIATRIC HEALTH QUESTIONNAIRE

DATE: __________ NAME (PRINT): ____

DATE OF BIRTH: ______________ AGE: _________ **GENDER**: ☐ **M** ☐ **F** **SEX AT BIRTH:** ☐ **M** ☐ **F**

BIRTH HISTORY

1. Birthplace ________________________________
2. Normal Pregnancy ☐ Yes ☐ No
3. Normal Delivery ☐ Yes ☐ No
4. Was baby full-term? ☐ Yes ☐ No

GROWTH AND DEVELOPMENT

1. Any development concerns? ____
   ____
2. Number of years in school: ____________________
3. Attends special school or classes? ☐ Yes ☐ No
4. Discipline or behavior problems? ☐ Yes ☐ No
   If yes, please explain: ____
   ____

PAST MEDICAL HISTORY

1. Please mark any of the listed major medical problems you child has: ☐ Asthma ☐ Allergies
   ☐ Depression ☐ Anxiety ☐ Diabetes ☐ Seizures ☐ Other ________________________________
2. Please list any serious injuries your child has had: ____
   ____
3. Has your child had chicken pox? ☐ Yes ☐ No If yes, what age? ________________
4. Had you child had any other contagious diseases (i.e.) measles, mumps, etc.? ☐ Yes ☐ No
   If yes, please list: ____
5. Immunizations (Shots)
   Please attach a vaccine history if available

MEDICATIONS

1. Please list all medications your child is currently taking: ____
   ____

HOSPITALIZATIONS

1. Please list any hospitalizations your child has had (when, where and why): __________________________
   ____
   ____

ALLERGIC REACTIONS

1. Does your child suffer from any allergic reactions (Drugs, Asthma, Hives, Eczema, Hay Fever, etc.)?
   ____

SOCIAL HISTORY

- Father's Age: __________ Health: ☐ Good ☐ Fair ☐ Poor ☐ Father is deceased
- Mother' Age: __________ Health: ☐ Good ☐ Fair ☐ Poor ☐ Mother is deceased
- Number of siblings: __________ Ages: _____________________
- Who has legal custody of the child? ____

FAMILY HISTORY

1. Please mark any history in the family of the following diseases: ☐ Diabetes ☐ Heart Disease
   ☐ Cancer ☐ TB ☐ Convulsions ☐ Seizures ☐ Allergies ☐ Other _____________________________

PLEASE TURN OVER AND COMPLETE

North Olympic Healthcare NETWORK

GENERAL

1. Is your child having currently having any specific issues or problems? ☐ Yes ☐ No
   If yes, please list here: ____
   ____

ANY SPECIAL COMMENTS ABOUT YOUR CHILD

____
____
____
____

CHILD'S LAST DOCTOR

Please list your child's last doctor: ____

Who completed this form? ____

Relationship to child? ____