North Olympic Healthcare NETWORK

# NORTH OLYMPIC HEALTHCARE NETWORK
# PEDIATRIC HEALTH QUESTIONNAIRE

DATE**:** _____ NAME (PRINT): _____

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

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## 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**

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**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? _____

Signature: _____ Date: _____