

NORTH OLYMPIC HEALTHCARE NETWORK
PEDIATRIC HEALTH QUESTIONNAIRE

DATE: _____ NAME (PRINT): _____

DATE OF BIRTH: _____ AGE: _____ SEX: ☐ 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: _____
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PAST MEDICAL HISTORY

1. Please mark any of the listed major medical problems your 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: _____
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HOSPITALIZATIONS

1. Please list any hospitalizations your child has had (when, where and why): _____
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ALLERGIC REACTIONS

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

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

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



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: _____