



# CARMEL VALLEY PEDIATRICS

comprehensive care and a gentle touch – woven together for healthy kids

## Patient Health Questionnaire

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Please check the NO or YES response box or answer the questions below

### Pregnancy and Birth

Mother's age at birth: \_\_\_\_\_

Maternal illness during pregnancy? No  Yes

Any meds other than vitamins & iron? No  Yes

Was the baby on time (>37 wks)? No  Yes

Was the baby breech? No  Yes

Did the baby have trouble while in the hospital? (jaundice, infection, breathing problems) No  Yes

### Past Medical History

Where has your child gone for check-ups last?

Date of last check-up? \_\_\_\_\_

Allergic reaction to meds, food, insects? No  Yes   
If yes, which ones & reaction

Any serious reactions to immunizations? No  Yes   
If yes, which ones & reaction

Any hospitalization besides birth? No  Yes   
If yes, for what?

Any serious injuries? No  Yes   
If yes, what kinds?

Medications taken regularly or currently? No  Yes   
If yes, which ones?

### Family History

Are the child's parents in good health? No  Yes

Circle any diseases that this child's parents, grandparents, siblings, aunts, uncles, cousins have had:  
*anemia, asthma, allergies, eczema, diabetes, tuberculosis, high blood pressure, heart trouble, high cholesterol, cancer, mental illness, drug problems, inherited illness, AIDS, learning disorder, attention deficit disorder or hyperactivity, strabismus, others:* \_\_\_\_\_

List general health of siblings:

Have any of your children died? No  Yes

### Feeding and Nutrition

Was there severe colic or any unusual feeding problem during the 1<sup>st</sup> 3 months? No  Yes

If breastfed, for how long? \_\_\_\_\_

Does your child take vitamins? No  Yes

Does your child take fluoride? No  Yes

Does your child use homeopathic or herbal medicines? No  Yes

### Review of Systems

HAS YOUR CHILD HAD:

Frequent ear infections? No  Yes

Eye problems, glasses? No  Yes

Frequent colds or sore throats? No  Yes

Chickenpox? No  Yes

Asthma, pneumonia, recurrent cough? No  Yes

Heart murmur or heart problems? No  Yes

Problems with urination, urine infections? No  Yes

Frequent diarrhea or constipation? No  Yes

Convulsions or other problems with the nervous system? No  Yes

Eczema, hives or other skin condition? No  Yes

Anemia or other blood problems? No  Yes

Please list any other medical problems:

List any sub-specialists your child has seen:

### Development and Behavior

Age child sat alone? \_\_\_\_\_

Age child walked alone? \_\_\_\_\_

Was child saying words by 18 months? No  Yes

Does child have trouble sleeping? No  Yes

What grade is child in? \_\_\_\_\_

Has child had any trouble in school? No  Yes

Does child get along with other children? No  Yes

Circle if your child has had any of the following:  
*Thumb sucking, bed wetting, problems with toilet training, hyperactivity, nightmares, speech problems, problems with discipline*

### Safety and Environment

Are the parents of the child: *married, divorced, separated, deceased*?

The child lives with: *both, one, joint custody, guardian, foster, stepmother, stepfather, other?* \_\_\_\_\_

Is the child adopted? No  Yes

The child is also in: *daycare, preschool, with nanny, with relatives*

Are there any pets at home? No  Yes

Are there any smokers exposed to the child? No  Yes

Do you have a pool, spa, pond? No  Yes

Does child always wear a helmet when bicycling or skating? No  Yes

Does child always use a car seat or belt? No  Yes

### Records

Do you have a record of immunization? No  Yes