

  
**Warwick**  
 PEDIATRICS  
 THE OFFICE OF  
 DOMINIC BERLINGIERI, MD, FAAP

## PEDIATRIC HISTORY QUESTIONNAIRE

Child's Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Primary Insurance: \_\_\_\_\_ Secondary Ins: \_\_\_\_\_

**Responsible Parties:**

Father/Guardian: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Mother/Guardian: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Are natural parents living together in household: \_\_\_\_\_  
 If not, where? \_\_\_\_\_

**Other people living in household:**

	Age
Brothers _____	
Sisters _____	
Others _____	

What was baby's due date? \_\_\_\_\_ Type of delivery: Vaginal \_\_\_\_\_ C-Section \_\_\_\_\_  
 Birth Weight \_\_\_\_\_ Length \_\_\_\_\_ Apgar Scores \_\_\_\_\_

Please check correct response: (needed)	<u>Yes</u>	<u>No</u>	<u>Explain</u> (use reverse side of form, if needed)
Any medical problems during pregnancy?	( )	( )	_____
Did mother do any of the following during pregnancy?			
Smoke	( )	( )	_____
Drink alcohol	( )	( )	_____
Use drugs	( )	( )	_____
Did baby have any problems in nursery?	( )	( )	_____
Any problems during the first month of life?	( )	( )	_____
Did mother have any problems during pregnancy? (i.e. problems with spouse, job, money, living arrangements)	( )	( )	_____ _____

**List all hospitalizations, major illnesses, accidents, broken bones:**

Date	Child's Age	Name of Hospital	Reason for Hospitalization
_____	_____	_____	_____

Any allergies to food or medication? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, please list them \_\_\_\_\_  
 List child's present medicines including vitamins and fluoride \_\_\_\_\_  
 Child's previous physician(s)? \_\_\_\_\_  
 Do you have a record of the child's immunization's? Yes \_\_\_\_\_ No \_\_\_\_\_ (Please provide a copy)

## Child's Development History

1. While child was growing up, or at present, have you noticed any difficulties in these areas?

	Yes	No	Age (years & months) when accomplished & comments)
a. Walking alone	( )	( )	_____
b. Speaking phrases (two words together)	( )	( )	_____
c. Bowel training	( )	( )	_____
d. Bladder training	( )	( )	_____

Has your child ever been diagnosed with a delay in developmental? \_\_\_\_\_  
 If yes, please state delay and provide any evaluations your child has had: \_\_\_\_\_

2. While the child was growing up, or at the present, have you noticed any difficulties in these areas?

	Yes	No	Age when difficulties became apparent & comments
a. Temper tantrums	( )	( )	_____
b. Fighting	( )	( )	_____
c. Difficulty making friends	( )	( )	_____
d. Academic problems	( )	( )	_____
e. Actively defies adult rules	( )	( )	_____
f. Anxiety / Nervousness	( )	( )	_____
g. Missing school	( )	( )	_____
h. Running away	( )	( )	_____

## Social History:

If in school, present grade? \_\_\_\_\_

What does child do in spare time? \_\_\_\_\_

How many hours a day does child watch TV? \_\_\_\_\_

Indicate any financial, interpersonal or family problems you are worried about \_\_\_\_\_

Are there guns in the home? \_\_\_\_\_

Does anyone in the home smoke? \_\_\_\_\_

Are there pets in the home? \_\_\_\_\_

Has child ever had counseling? \_\_\_\_\_

## Family History:

Check any of the following problems and which relatives have them (including natural parents, siblings, aunts, uncles and grandparents):

Eczema _____	Anemia _____
Seizure disorder _____	Alcoholism / drug abuse _____
Tuberculosis _____	Kidney disease _____
Allergies _____	Cystic fibrosis _____
Asthma _____	Cancer _____
High Blood Pressure _____	Mental retardation _____
Heart attack, stroke (under 55 yrs of age) _____	Birth defects _____
Diabetes _____	Emotional problems _____
Obesity _____	Death before 50 yrs of age, other than accident _____
High cholesterol or Triglycerides _____	Domestic violence _____
Legal problems _____	Behavioral problems _____
	Learning problems _____

**Review of Systems (has your child had any of the following):**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Skin trouble            | <input type="checkbox"/> Frequent diarrhea           | <input type="checkbox"/> Frequent headaches  |
| <input type="checkbox"/> Eye problems            | <input type="checkbox"/> Frequent constipation       | <input type="checkbox"/> Behavioral problems |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Black stool                 | <input type="checkbox"/> Rheumatic fever     |
| <input type="checkbox"/> Difficulty hearing      | <input type="checkbox"/> Kidney or bladder infection | <input type="checkbox"/> Measles             |
| <input type="checkbox"/> Frequent nose bleeds    | <input type="checkbox"/> Painful urination           | <input type="checkbox"/> Chicken Pox         |
| <input type="checkbox"/> Frequent sore throats   | <input type="checkbox"/> Bedwetting                  | <input type="checkbox"/> Mumps               |
| <input type="checkbox"/> Pneumonia               | <input type="checkbox"/> Painful periods             | <input type="checkbox"/> Rubella             |
| <input type="checkbox"/> Any other lung problems | <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Whooping cough      |
| <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Joint aches or pains        | <input type="checkbox"/> Hepatitis           |
| <input type="checkbox"/> Jaundice                | <input type="checkbox"/> Loss of consciousness       | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> Frequent stomach aches  | <input type="checkbox"/> Seizures                    | _____  |

**Any additional comments:** \_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

This form completed by: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Reviewed by: (MD, NP, PA) Signature \_\_\_\_\_

Date \_\_\_\_\_