Capital Area Pediatrics

HEALTH QUESTIONNAIRE

Please complete one form for EACH child

Patient Name _____ **Patient DOB:** _____ **Email:** _____

Completed by: _____ (Mother, Father, Guardian) Date: _____

Current Medications (include Non – prescription and herbal supplements / vitamins)

Name of Medicine	Strength of Dose (Mg)	How Often Taken	Reason Taken

Medical Equipment

Equipment (nebulizer, hearing aid, other durable equipment)	Reason

Allergies/Reactions

Name of medication, food, latex or other allergy	Describe reaction: hives (rash), swelling (mouth or face), anaphylaxis (trouble breathing), or stomach upset	Date or age of last reaction if you remember

Specialists Providing Ongoing Care

NAME	Specialty/Reason

Preferred Pharmacy(s)

Name	Address	Phone

Capital Area Pediatrics

Patient Name _____

Patient DOB _____

Past Medical History (please check all that apply)

☐ UNREMARKABLE

Allergy/Asthma/Respiratory
- ☐ Anaphylaxis
- ☐ Asthma
- ☐ Bronchitis, recurrent
- ☐ Bronchiolitis or RSV
- ☐ Wheezing or inhaler use
- ☐ Eczema
- ☐ Food Allergies, severe
- ☐ Seasonal allergies
- ☐ Immune Disorder
- ☐ Pneumonia, recurrent

Cardiology
- ☐ Congenital Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol

Development/Learning
- ☐ ADD/ADHD
- ☐ Autism
- ☐ Asperger's
- ☐ Developmental Delay
- ☐ Dyslexia
- ☐ Learning Problem
- ☐ Speech/Language Delay

ENT
- ☐ Ear Infection, recurrent
- ☐ Hearing problem
- ☐ Sinusitis, chronic
- ☐ Strep, recurrent

Gastrointestinal
- ☐ Crohn's Disease
- ☐ Chronic Abdominal Pain
- ☐ Constipation
- ☐ GERD/ Reflux

Hematology/Oncology
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Cancer _____

Infection
- ☐ Chicken Pox, age_____
- ☐ TB Test Positive

Mental Health
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Eating Disorder
- ☐ Substance Abuse
- ☐ Inpatient Psychiatric

Other
- ☐ Eye or vision problem
- ☐ Diabetes, age _____
- ☐ Thyroid Disorder
- ☐ Kidney Disease
- ☐ UTI, recurrent
- ☐ Liver Disease
- ☐ Hepatitis A B C
- ☐ Neurologic Disorder
- ☐ Seizures
- ☐ Tic Disorder
- ☐ Skin condition, other__
- ☐ Other _____

Birth History
- ☐ Full-term
- ☐ Premature, weeks ____
- ☐ Vaginal delivery
- ☐ C-Section
- ☐ Complicated pregnancy_____
- ☐ Complicated delivery__
- ☐ NICU _____

Past Surgical History (check all that apply)

SURGERY	Year	SURGERY	Year	Diagnostic Test/Procedure	Result/Yr	Evaluations	Year
☐ NONE		☐ Hernia Repair	_____	☐ CT Scan	_____	☐ PsychEd Assess	_____
☐ Appendectomy	_____	☐ Tonsillectomy	_____	☐ ECHO	_____	☐ IEP	_____
☐ Adenoids removed	_____	☐ G-Tube Placement	_____	☐ EEG	_____	☐ 504 Plan	_____
☐ Ear Tubes	_____	☐ Surgery Heart	_____	☐ MRI	_____	☐ OT-PT Eval	_____
☐ Sinus Surgery	_____	☐ Surgery Orthopedic	_____	☐ Ultrasound	_____	☐ Speech Eval	_____
		☐ Surgery, other	_____	☐ Other	_____	☐ Other	_____

Family History (check all that apply M=Mother/F=Father/S=Sibling)

- ☐ Alcoholism (M / F / S)
- ☐ Anemia (M / F / S)
- ☐ Anesthetic Complications (M/F/S)
- ☐ Anxiety (M / F / S)
- ☐ Asthma (M / F / S)
- ☐ Autoimmune Disorders (M / F / S)
- ☐ Birth Defects (M / F / S)
- ☐ Blood Clots (M / F / S)
- ☐ Breast Cancer (M / F / S)
- ☐ Cancer (M / F / S)
- ☐ Depression (M / F / S)
- ☐ Diabetes (M / F / S)
- ☐ Eczema (M / F / S)
- ☐ Endometriosis (M / F / S)
- ☐ Growth Development (M / F / S)
- ☐ Heart Disease <50 (M / F / S)
- ☐ Hepatitis (M / F / S)
- ☐ High Cholesterol (M / F / S)
- ☐ Hypertension (M / F / S)
- ☐ Immune Disorders (M / F / S)
- ☐ Infertility (M / F / S)
- ☐ Kidney Disease (M / F / S)
- ☐ Lipid Disorder (M / F / S)
- ☐ Liver Disease (M / F / S)
- ☐ Migraine (M / F / S)
- ☐ Osteoporosis (M / F / S)
- ☐ Psychiatric Care (M / F / S)
- ☐ Respiratory Disease (M/F/S)
- ☐ Seizures (M / F / S)
- ☐ Seasonal Allergies (M / F / S)
- ☐ Severe Allergy Rx (M / F / S)
- ☐ Stroke < 50 yrs (M / F / S)
- ☐ Sudden Death <50 (M / F / S)
- ☐ Thyroid Disease (M / F / S)
- ☐ Ulcers (M / F / S)

Social History (check all that apply)

- ☐ Daycare
- ☐ Foreign born _____
- ☐ Foreign travel_____
- ☐ Adopted
- ☐ Both parents in home
- ☐ Single parent household
- ☐ Shares two households
- ☐ Lives with guardian
- ☐ Foster care
- ☐ Deceased parent (M/F)
- ☐ Deceased Sibling___
- ☐ Well-water
- ☐ Exclusive bottled water
- ☐ Vegetarian family
- ☐ Smoke exposure
- ☐ Pets in home