**GREAT RIVER PEDIATRIC HEALTH QUESTIONNAIRE**

|  |  |
| --- | --- |
| Mother & Age | Father & Age |

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
INSTRUCTIONS: Please print or write legibly, Fill additional sheets out for each child. Only one (1) SOCIAL AND FAMILY History form needs to be completed. Comment on specifics.  
  
List all Children and DOB (Date of Birth)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY SOCIAL HISTORY (SH)**Parent's marital status:

Single  Married  Divorced and who has custody? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
What are your living arrangements?  
 House (Age? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  Rent  Own  Apartment  
  
How many adults live in the household? \_\_\_\_\_\_\_ How many children live in the household? \_\_\_\_\_\_\_\_  
  
Parents Employed? Mother? Y N By Whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Father? Y N By Whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**: "M" indicates Maternal (Mother's) side, "F" indicates Paternal (Father') side:  
**M F Disease M F Disease**  Unknown/No Information   Heart disease  
  No inheritable medical problems   Heartburn (GERD)  
  Alcoholism / drug use   High cholesterol  
  Allergies   High blood pressure  
  Asthma   Hyperthyroid (over-active thyroid)  
  Bleeding disorders   Hypothyroid (under-active thyroid)  
  Cancer   Iron deficiency / anemia  
  Cerebrovascular disease (stroke)   Kidney disease  
  Crohn's disease   Lupus  
  Depression   Mental illness(other than depression)  
  Diabetes   Rheumatoid arthritis  
  Eczema   Seizures  
  Early heart attacks ( age 50)   Tuberculosis  
  Hearing loss   Ulcerative colitis  
List any other inherited health issues or serious health problems present in either side of the family not covered on the list above:  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GREAT RIVER PEDIATRICS**

|  |  |
| --- | --- |
| Patient Name | DOB |

**Fill out a page for each child.  
  
All Children Pediatrics HEALTH QUESTIONNAIRE**INSTRUCTIONS: Please print or write legibly. Fill additional sheets out for each child. **Only one (1)** SOCIAL AND FAMILY History form needs to be completed. Comment on specifics.  
**MEDICATIONS**: List all current medications and strengths your child is on:  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES:**   
 Drug Allergies: List all \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Allergic Rhinitis  Asthma  Urticaria (hives)  
 Eczema / chronic dry skin  Food intolerance  
  
**NEWBORN PERIOD:** Vaginal Delivery  C-Section  Difficult Delivery  
 Term  Premature  Birth Weight \_\_\_\_\_\_\_\_\_\_\_  
 Jaundice?  Phototherapy?  Heart or lung problems  
 Feeding problems  Delayed discharge home from nursery  
 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 **FEEDING AND DIGESTION:**  
 Breast fed  Bottle fed  Appetite poor  
 Vomiting  Chronic loose stools  Constipation issues  
 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFECTIONS, DEVELOPMENT, MISCELLANEOUS PROBLEMS:** Dental problems  Developmental delays  Eye problems (glasses. etc)  
 Frequent sore throats  Frequent ear infections  Hearing loss  
 Heart problems  Elevated blood pressure  Seizures  
 Pneumonia  Pica (eating dirt, plants. etc.)  Orthopedic problems  
 Kidney or bladder infections Bed wetting    
 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
**SURGICAL PROCEDURES and HOSPITALIZATIONS:** Tonsillectomy, adenoidectomy and/or ear tubes  Other surgical procedures  
 Serious injuries (concussions, broken bones, etc)   
 Hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PSYCHOLOGICAL PROBLEMS:** Antisocial behavior  ADHD issues  Drug use/abuse  
 Discipline problems  Breath holding  School adjustment problems  
 Peer relationships  Tics/ nervoL1s habits  Learning disability  
 Mental retardation  Nightmares  Temper tantrums  
 Speech problems  Poor school performance  Anxiety  
 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_