

**KILLEEN PEDIATRIC CARE CLINIC, PA
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Pediatric – Patient Questionnaire

PT Name: _____ Date: _____	
Completed By: _____ Relation: _____ Prev. Dr. _____	
Reason for today's Visit: _____	
<p>PREGNANCY AND BIRTH</p> <p>Mothers age at pregnancy? _____</p> <p>Any illness during pregnancy? Y N _____</p> <p>Medications during pregnancy? Y N _____ (exclude vitamins & iron)</p> <p>During Pregnancy: Smoking Alcohol Street drugs</p> <p>Was baby: Early # of wks Late On time Type of Delivery:</p> <p>Birth Weight: _____ Length: _____</p> <p>Complications? Y N _____</p> <p>Problems with Baby at birth? Breathing Y N Jaundice Y N Other _____</p> <p>Problems soon after? Nursery or home? _____</p> <p>Past Medical History: Allergic reactions? Medicine Y N Food Y N Animals Y N Insect bites Y N Medication taken on a regular basis? (exclude vitamin) _____</p> <p>Immunizations up to date? Y N Do you have a record? Y N Hospitalizations (when-where-why?) _____</p> <p>Serious Injuries (when-where?) _____</p> <p>Red Measles Y N Mumps Y N German Measles (3 day) Y N Chicken Pox Y N Whooping Cough Y N Rheumatic Fever Y N Scarlet Fever Y N Eczema/Hives Y N Seizures Y N Anemia Y N Hepatitis Y N Asthma/Wheezing Y N Recurrent Ear Infections (3 or more) Y N Throat Y N Problems with? Hearing Y N Vision Y N Blood Transfusions? Y N Bleeding tendency? Y N Other? _____</p>	<p>Family Medical History: List all blood relatives of your child who have had the following problems, Use abbrev. ((F) Father (M) Mother (S) Sister (B) Brother (MM) Mother's Mother (MF) Mother's Father (FM) Father's Mother (FF) Father's Father (A) Aunt (U) Uncle (C) Cousin</p> <p>Anemia/Blood Dis _____</p> <p>Asthma _____</p> <p>Allergies/Sinus _____</p> <p>Drug Problem _____</p> <p>Alcoholism _____</p> <p>Cancer _____</p> <p>Aids _____</p> <p>Cystic Fibrosis _____</p> <p>Musc. Dystrophy _____</p> <p>Tuberculosis _____</p> <p>Arthritis _____</p> <p>Epilepsy/Seizures _____</p> <p>Heart Disease _____</p> <p>High Blood Pressure _____</p> <p>Cholesterol Problem _____</p> <p>Migraine _____</p> <p>Sudden Infant Death _____</p> <p>Birth Defects _____</p> <p>Early Deafness _____</p> <p>Diabetes _____</p> <p>Mental Retardation _____</p> <p>Mental Illness _____</p> <p>ADHD _____</p>
<p>Feeding & Nutrition</p> <p>Food Allergies? _____ Appetite usually good? Y N</p> <p>Colic or feeding problems during the first 3 months? Y N</p> <p>Breast feed? Y N Number of Months? _____</p> <p>Formula? Y N Current Brand? _____</p> <p>Vitamins? Y N Brand? _____ Fluoride? Y N</p> <p>Special Diet? _____</p> <p>Family Profile: Parents (circle): Married – Separated – Divorced - Single</p> <p>Father's Age? _____ Highest school grade? _____ Health? _____</p> <p>Mother's Age? _____ Highest school grade? _____ Health? _____</p> <p>Mother's occupation? _____ Father's occupation? _____</p> <p>Smoking? Y N Who? _____</p> <p>Pets? Y N What type of pets? _____</p> <p>List Child's brothers, sisters and their ages? _____</p>	<p>Development & Behavior</p> <p>Age at which: Sat Alone _____ Walked _____</p> <p>Used Sentences _____ Toilet trained _____</p> <p>Bicycled _____ Development compared to other children? _____</p> <p>Learning Problems? Y N</p> <p>Gets along with other children? Y N</p> <p>Behavior Problems? Y N</p> <p>Speech Problems? Y N</p> <p>Bad Habits? Y N</p> <p>Bedwetting? Y N</p> <p>Nail Biting? Y N Sleeping? Y N</p> <p>Hobbies - Sports- Social Activities? _____</p> <p>Use of street or illegal drugs? Y N _____</p> <p>Grades in school? _____</p> <p>Problems in School? _____</p> <p>Language Spoken at Home? _____</p>