

RAPPAHANNOCK FAMILY PHYSICIANS
Pediatric Health History Questionnaire

Today's Date: _____

Child's Name: _____ Age: _____ Date of Birth: _____

Parents' Names: Mother _____ Father _____

Siblings' Names and Ages: _____

List All Substances (including medications and foods) to which the child has an Allergy.

BIRTH HISTORY

Was the child premature (born early)? Yes _____ No _____

Were there any complications with the birth? Yes _____ No _____

If yes, please explain _____

What was the baby's birth weight? _____ lb. _____ ounces

How was the baby born? Vaginal _____ Cesarean _____

GROWTH AND DEVELOPMENT

Do you have any concerns about your child's growth and development? Yes _____ No _____

If yes, please explain _____

Do you have any concerns about your child's speech and/or hearing? Yes _____ No _____

If yes, please explain _____

Do you have any concerns about your child's behavior? Yes _____ No _____

If yes, please explain _____

Do you have any concerns about your child's performance at school? Yes _____ No _____

If yes, please explain _____

Are your child's immunizations up-to-date? Yes _____ No _____

Is your child regularly exposed to cigarette or cigar smoke? Yes _____ No _____

PAST MEDICAL HISTORY

Please list all hospitalizations and surgeries:

Date	Description	Date	Description
_____	_____	_____	_____
_____	_____	_____	_____

Please list any current or past health problems:

Date	Description	Date	Description
_____	_____	_____	_____
_____	_____	_____	_____

Please list all medications (both prescription and non-prescription) that your child regularly takes:

