LUV-N-CARE PEDIATRICS

11811 Fallbrook Dr., Suite B-2
HOUSTON, TEXAS 77065

New Patient Medical History Questionnaire (CHILD)

DATE: _______/_______/________

Mothers Name: ________________________ Age: _____
Mothers occupation: _______________________________
Fathers Name: _________________________ Age: _____
Fathers occupation: ________________________________
Who does child live with? : __________________________

Childs Name: ____
DOB: _____/______/_______ Age: __________ days weeks months years

Who cares for child on regular basis? : ______________________________
____

Pregnancy and Birth

Mothers age at birth: _______
Any illnesses during pregnancy? YES NO
____
____
Baby's birth weight: ________ lbs. ________ oz.
Did baby have any complications at birth? YES NO
If YES please explain: ______________________________
____
____

Past medical history

Who is your child's previous physician?: ______________
____
Date of last check up: ______________________________
Date of last dental check up: _________________________
Allergies to medicine: ______________________________
Allergies to food: __________________________________
Any serious injuries?: ______________________________
____
Any hospitalizations: ______________________________
____
Current medications: ______________________________
____
____

Family History

Are both parents in good health? YES NO
List names and ages of siblings:
____
____
____

Review of Systems

Has your child had any of the following:
recurrent ear infections sore throat teeth problems eye problems
asthma heart murmur wheezing frequent urination recurrent diarrhea
seizures skin problems

Development and Behavior

At what age did your child sit up alone: ______________________________
At what age did your child start walking: _____________________________
At what age did your child start talking: ______________________________
How does your child compare to other children his/her age: ________________
____
____
What grade is your child in: _______________
Any problems in school: ____
____
____
Circle any problems that your child has had or having:
biting others nail biting thumb sucking bed wetting bad temper nightmares
hyperactivity speech problems sleepwalking discipline difficulty

Safety and Environment

Do you live in: an apartment mobile home house
What setting is your water heater on: ____________________________________
Are there any smokers in the house? : YES NO
If answered yes, who: ____
If answered yes, where: ____
____
Are there working smoke alarms in your home: YES NO
Are there any problems with your home?
Peeling paint insects rats mice other: ___________________________
____

Feeding and Nutrition:

Is your child's appetite good? YES NO
Did your child have colic or other feeding problems the first 3 months of life? YES NO
Was child: BREAST FED BOTTLE FED BOTH
What formula was used: ____
Does child take vitamins: YES NO If so, which kind: ____
Any additional important health history:
____
____
____
____
____
____