



LUV-N-CARE PEDIATRICS
11037 FM 1960 West, Suite B-2A
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: _____

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: _____

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: _____
