



WESLEY CHAPEL

INTERNAL MEDICINE AND PEDIATRICS

CHILD HEALTH HISTORY QUESTIONNAIRE

Please complete this to the best of you abilities, this will help us to better care for your child.

Name: (Last, First, MI) _____

Childs Previous Pediatrician: _____

Date of last physical exam: _____

A. Birth History

- Who was the Mother's obstetrician? : _____ Date begun: _____
- Any problems with the pregnancy? YES NO
- Full term? YES NO
If not full term, how many weeks? _____
What was baby's birth weight? : _____ length? _____
- Delivered at: (Name of Hospital) _____
Vaginal _____ C-section _____
- Problems at delivery? Mother? YES NO Baby? YES NO
Type of problem _____
- Do you know if Tobacco, alcohol, or drugs were used during pregnancy? YES NO

B. Past Medical History

- Where has your child gone for checkups? _____
- Date of last visit to Doctor: _____
Dentist: _____
- Allergy to: _____
- Any reactions to shots? YES NO
Please explain: _____
- Any hospitalizations, accidents, injuries? YES NO
- Is child taking medicines? YES NO
What kind? _____

C. FEEDING & NUTRITION

- Is your child's appetite usually good? YES NO
- Any colic, spitting, feeding problems? YES NO
- Check: Breast Bottle Type of formula _____
- Does your child eat things that are not food? YES NO
What? _____

D. DEVELOPMENT & BEHAVIOR

- At what age did your child sit alone? _____
- At what age did your child walk alone? _____
- Did your child say words by 18 months? YES NO
- At what age was your child toilet trained? _____
- Does your child wet the bed? YES NO
- Does your child have trouble sleeping? YES NO
- Does your child play well with others? YES NO
- Has your child repeated a grade in school? YES NO



Nutritional supplement information: (continued)

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| 5. If this Practice offered natural alternatives to prescriptions, when applicable, would you be interested in these alternatives? | YES | NO |
| 6. If this Practice offered a comprehensive weight management program, would you consider it? | YES | NO |
| 7. If this Practice offered a nutrition education program to improve your dietary habits, would you consider it? | YES | NO |
| by appointment with one of our staff? | YES | NO |
| by a class exclusively for our patients? | YES | NO |

PRINT NAME PLEASE

(Relationship)

Date: _____

