PEDIATRIC ASSOCIATES OF DALLAS
HISTORY QUESTIONNAIRE
(TO BE COMPLETED BY THE LEGAL GUARDIAN)

(Complete for all age patients)

Patient Name: _____ **Date of Birth:** _____

A. Mother's Prenatal History

Number of pregnancies _____ Number of living children _____ Name of Obstetrician _____
Did you have any of the following health problems during your pregnancy: Bleeding_____ High Blood Pressure _____
Surgery _____ Anemia _____ Infections _____ Accidents _____ Swelling _____ Other _____
_____
Were any of the following used or taken during your pregnancy: Medications _____
Cigarettes _____ Alcohol _____ Drugs _____

B. Birth History

Where was your child born: _____ Number of weeks pregnant: _____
Was labor induced: _____ Hours of labor:_____ Was this a multiple birth: _____
Medication: _____ Type of delivery: ☐ Vaginal ☐ Forceps ☐ Cesarean
Problems or complications during labor or delivery: _____
Child's birth weight:_____ Length: _____ APGAR Score: _____
Type of feeding: Breast _____ Formula _____ Both _____
Did the child have problems in the hospital: Breathing _____ Color_____ Feeding _____ Temperature _____
Other _____
Did the child go home with you?_____ If no, when? _____ Discharge weight:_____

C. Family History

Age of child's mother at delivery: _____ Father: _____ Siblings: _____
Health problems of child's parents: _____
Health problems of child's siblings: _____

D. List below any of child's relatives (mother, father, siblings, grandparents, aunts, uncles) who have had the following illnesses.

CONDITION	NO	YES	FAMILY MEMBER
Allergies			
Anemia			
Arthritis			
Asthma, Emphysema, T.B.			
Birth Defects			
Blood Disease			
Bone/Muscle Disease			
Cancer (specify)			
Cystic Fibrosis			
Diabetes ( ) Adult ( ) Juvenile			
Drug / Alcohol Abuse			
Eye / Ear Disorders			
Heart Disease			
High Blood Pressure			
Infections (Frequent / Severe)			
Kidney / Liver Disease			
Learning Problems			
Mental Illness / Retardation			
Metabolic / Genetic Disease			
Nerve Disorder (Epilepsy, C.P.)			
Rheumatic Fever			
Sickle Cell Trait / Disease			
TB or Exposure			
Thyroid Disease			

(Please see other side)

Patient Name: _____ **Date of Birth:** _____

(Complete applicable information for all age patients)

E. Child's Health History

Adverse reactions to medications (explain) _____
Adverse reactions following Immunizations (explain) _____
Hospitalizations _____
Operations _____
Emergency Room Visits _____
Does your child seem to be developing normally? _____
Does your child hear well? _____
Does your child see well? _____
Is your child's speech understandable most of the time? _____
Age when toilet trained _____
Does your child have any current problems? _____
Do you have any concerns about your child? _____
Has your child ever had any of the following? If yes, please list age.

CONDITION	NO	YES	AGE
Allergies			
Anemia			
Asthma			
Bleeding			
Cancer			
Chicken Pox			
Constipation, Chronic			
Convulsions			
Diarrhea, Chronic			
Ear Problems			
Eye Problems			
Fractures			
Kidney Infection			
Leukemia			
Measles			
Meningitis			
Pneumonia			
Scarlet Fever			
Sickle Cell			
Tonsillitis			
Whooping Cough			
Other			