

Dr. Joel & Carol Bower
School Based Health Center
Pediatric Questionnaire

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Phone number: _____

Relationship to child: _____ Alt. Phone: _____

Why are you bringing your child to the Health Center today? _____

With whom does the child live with most of the time?: (List all that apply)

Mother Father Stepmother Stepfather Guardian

Sister(s): ages _____ Brother(s): ages _____

Other Adult(s): _____

Other _____

In the past year, have there been any changes in your family?

Marriage Separation Divorce Loss of job

A new school Births Deaths Serious illness

Move to new neighborhood Other: _____

Yes No Has your child ever been hospitalized overnight?

(When and Why) _____

Yes No Has your child ever had any serious injuries? (Please list) _____

Yes No Has your child ever broken any bones? (Please list) _____

Yes No Has your child been seen by a dentist? Any concerns? _____

Yes No Are your child's immunizations up to date? Copy provided? Yes No

Yes No Does anyone smoke in the house?

Yes No Does your child wear a seatbelt?

Yes No Does your child attend school? Name of School: _____

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

Yes No Do you have any concerns about your child's relationship with teachers,
friends, classmates or siblings?

Yes No Do you have concerns about your child's eating habits?

Yes No Are there any other Health Concerns?

How many hours does your child sleep per night? _____

Naps (number and Length): _____

Any sleep problems? _____

Does your child play any organized sports? _____

Does your child have any health condition that interferes with sports or normal play? _____

- Yes No Do you feel your child speaks normally?
Yes No Do you feel your child hears normally?
Yes No Do you feel your child's behavior is normal?
Yes No Do you feel your child's growth is normal?

Medical History

Please check if your child has ever had any of the following health problems diagnosed by a doctor: (explain)

Problem	Yes	No	Age	Problem	Yes	No	age
ADHD/ Learning disability				Headaches/ Migraines			
Allergies/ hayfever				Anemia (Low iron in blood)			
Asthma				Pneumonia			
Bladder/ Kidney Infections				Rheumatic fever/ heart disease			
Blood disorders/ Sickle Cell				Scoliosis (curved spine)			
Cancer				Seizures/ Epilepsy			
Chicken Pox				Stomach problems			
Diabetes				Tuberculosis/ Lung disease			
Eating disorder				Steroid use/ Anti cancer drugs			
Emotional disorder				Blood transfusions			
Frequent Infections				Sexual, physical or emotional abuse			
Hepatitis/ Liver disorder				Medical problems after birth			

Other health problems not listed:

Medications your child is taking:

<u>Medication</u>	<u>Reason taken</u>	<u>How long taken</u>
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Family History

Some health problems are passed from one generation to the next. Have you or any blood relative (parents, grandparents, aunts, uncles, brother or sisters) living or deceased, had any of the following problems? If yes, state relationship:

Problem	Yes	No	Relationship	Problem	Yes	No	Relationship
Allergies/ Asthma				High Blood pressure			
Arthritis				High Cholesterol			
Birth defects				Kidney disease			
Blood disorder/Sickle cell anemia				Learning disability			
Cancer:				Liver disease			
Depression				Mental Health			
Diabetes				Mental retardation			
Alcoholism/drinking				Migraine headaches			
Drug addiction				Obesity			
Endocrine/ gland disease				Seizures/epilepsy			
Heart attack/stroke				TB/ Lung disease			

Other family illnesses: _____
