WESLEYCHAPEL
INTERNAL MEDICINE AND PEDIATRICS
Manish Shah MD, FAAP

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

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

B. Past Medical History

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

C. FEEDING & NUTRITION

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

D. DEVELOPMENT & BEHAVIOR

1. At what age did your child sit alone? _____
2. At what age did your child walk alone? _____
3. Did your child say words by 18 months? YES NO
4. At what age was your child toilet trained? _____
5. Does your child wet the bed? YES NO
6. Does your child have trouble sleeping? YES NO
7. Does your child play well with others? YES NO
8. Has your child repeated a grade in school? YES NO

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D. DEVELOPMENT & BEHAVIOR (continued)

9. What grade level is your child in at school? _____
10. What kind of grades is your child getting in school? *A, B, C, D, F*

E. SAFETY & ENVIRONMENT

1. Where does the family live? House Apartment Mobile home Other _____
2. How many people live in the home? _____ Language spoken in home? _____
3. Who takes care of the child most of the time? Parent relative babysitter daycare other
4. Is there a working smoke detector on each floor? YES NO
5. Does anyone in the household smoke? YES NO
6. What type of drinking water does the home have? county/city well bottled
7. Have you ever suspected your child has been mistreated? YES NO
8. Are there guns in the home? YES NO

F. FAMILY & CHILD MEDICAL HISTORY

Check any health problems for child, child's parents, grandparent's, brothers, sisters, aunts and uncles.

	Child	Family		Child	Family
Allergies			Hepatitis/Liver Disease		
Anemia-Low Blood Iron			High Blood Pressure		
Asthma/Bronchitis/Pneumonia			HIV/AIDS		
Birth defects/Retardation			Learning problems/ADHD		
Bladder/Kidney Problems			Mental illness/Suicide		
Cancer			Muscle/Joint/Bone pain		
Dental problems			Sexually transmitted diseases		
Diabetes (sugar)			Skin Problems		
Diarrhea/Constipation			Sore throat/Frequent colds		
Drug/Alcohol/Tobacco use			Thalassemia/Sickle cell		
Ear Problems/Tubes/Deafness			Tuberculosis		
Epilepsy/Seizures			Vision/Eye problems		
Heart problems/Murmurs			Other		

NUTRITIONAL SUPPLEMENT INFORMATION:

1. Is your child presently taking any type of nutritional supplements?
   (Such as vitamins, minerals, herbs, amino acids, fish oils, etc)? YES NO

Name the supplements they are presently taking?

2. Who recommended you to take these supplements? _____
3. Where did you purchase these supplements? _____
4. If this Practice offered an advanced, high quality line of supplements, would you consider purchasing them? YES NO

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Nutritional supplement information: (continued)

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?
   by appointment with one of our staff? YES NO
   by a class exclusively for our patients? YES NO

_____ Date: _____
PRINT NAME PLEASE (Relationship)