

Pediatric Associates of Wellesley History Form

Dear Parent,

This is a health questionnaire for your child. **Please complete this form and bring it with you at the time of your first appointment.**

Date completed: _____

Child's Name: _____

Date of Birth: _____

Mother's Name: _____

Father's/Partner's Name: _____

FAMILY HISTORY

1. Mother Age: _____ Occupation:

Past Health Problems:

2. Father/ Partner Age: _____ Occupation:

Past Health Problems:

3. Marital Status of Parents:

4. Other Children in Family:

Dates of Birth Name State of Health

- _____
- _____
- _____
- _____

5. Are there cultural or religious practices that might affect your child's medical care?

YES NO

If yes, please explain: (examples: blood transfusion, dietary rules):

6. Is there a history in the **family/ blood relative** with:

- Tuberculosis YES NO

- Diabetes YES NO
- Asthma, hay fever, eczema, allergies YES NO
- Psychiatric Disorder YES NO
- Substance Abuse YES NO
- Celiac disease YES NO
- Heart disease, stroke, high cholesterol YES NO
- Cancer YES NO

If yes, what kind: _____

- Birth defects, genetic defects YES NO
- Melanoma YES NO
- Autism YES NO
- Other serious medical problems YES NO

PRENATAL HISTORY

Were there any problems during the delivery or pregnancy of your baby?

- Was baby born early: (less than 38 weeks) YES NO
- Was baby born late (after 42 weeks) YES NO

- Birth weight of baby:

- Did baby remain in hospital longer than mother? YES NO

- How was baby fed?

‘ Breast

‘ Bottle

DEVELOPMENTAL HISTORY:

Has your previous pediatrician ever had concerns about your child’s development, if yes please explain:

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IMMUNIZATIONS

PLEASE GIVE US A COPY OF PREVIOUS IMMUNIZATIONS/VACCINES and TB (Tuberculosis) Testing, and Lead test results

PAST MEDICAL HISTORY: Has the child had:

a. Hospitalizations YES NO

If yes, what illness? _____

b. surgeries YES NO

if yes, for what? _____

c. Other serious medical illnesses: YES NO If yes, what kind?

d. Is your child currently taking any medications, vitamins, or herbs: YES NO

Medications	dose	How often
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_____	_____	_____
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_____	_____	_____
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_____	_____	_____
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e. Reaction to drug or foods (allergy) YES NO

If yes, please explain:

f. Are there concerns about physical, sexual, or emotional abuse? YES NO