# Family Physicians of O'Fallon

*****It is very important that you bring in your child's immunization records when you turn in this questionnaire or at their appointment.*****

## Pediatric Questionnaire

**Patient Name: _____**
First Last Middle initial

Address: _____
What phone number can someone be reached at? _____
Date of Birth: _____
Which provider will you be seeing? _____
Appointment date and time: _____

## Past Medical History

**Birth History- Please complete birth history for children 18 months and younger**

Length of pregnancy: _____

Birth Weight_____

Problems with pregnancy, labor, or delivery:_____

Any problems at birth: _____

**List Current Medications: (Please include over-the-counter medications and vitamins)**

Name dose how often you take

_____
_____
_____
_____
_____
_____
_____

**Any known drug allergies**:

_____

**Chronic / Past Medical problems: (Include childhood diseases such as chicken pox)**

_____

_____

**List Past Surgeries: Include dates if known**

_____

_____

**List previous hospitalizations: (Other than surgeries)**

_____
_____
_____
_____
_____
_____

## Social history:

Who lives at home? (Names and ages of parents/step-parents, siblings)

_____

_____

Does your child attend daycare in a home or daycare setting? _____

Name of school and grade level _____

Any concerns about school performance? _____

Any concerns about social interactions with friends?_____

What type of sports/activities/hobbies does your child participate in?

_____

Any smokers in the home? _____

Any pets in the home? _____

## For children 12 years of age and older, please complete the following:

Any concerns with alcohol consumption: Yes No

Any concerns with Illicit/ Illegal drug usage: Yes No
Current Drugs Used:_____

Past drugs Used:_____

Any concerns with cigarette smoking or chewing tobacco use? Yes No

History of sexual activity? Yes No

Any prior pregnancies? Yes No

Any history of STD's? Yes No

## Family History (circle answer and fill in applicable blanks)

For each listed below please indicate age, living or deceased, current medical conditions and / or cause of death

Father: age_____ living/deceased
medical problems:_____

Mother age_____ living/deceased
Medical problems: _____

Brother: age_____ living/deceased
medical problems:_____

Brother: age_____ living/deceased
Medical problems:_____

Brother: age_____ living/deceased
medical problems:_____

Brother: age_____ living/deceased
Medical problems:_____

Sister: age_____ living/deceased
Medical problems:_____

Sister: age_____ living/deceased
medical problems:_____

Sister: age_____ living/deceased
Medical problems:_____

Sister: age_____ living/deceased
medical problems:_____

Do any other family members have a history of any of the following diseases or conditions?

Diabetes Hypertension Cancer Heart Disease Kidney Disease

High cholesterol Other:_____

If so, please indicate who. _____