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| **Pediatric Health History Questionnaire:**  **Seaside Wellness of Shallotte** | |
| Child's name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Mother's name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Father's name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Siblings names and ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
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| **Pregnancy and Birth History** | |
| Mother's age at birth: | Father's age at birth: |
| Did mother have any of the following during pregnancy? | |
| € Fever or rash | € Tobacco use (how much) |
| € Group B strep | € Alcohol use (how much) |
| € Sugar in urine / diabetes | € Street drug use (what type) |
| € High blood pressure | € Medication use (prescription or over-the-counter - list below) |
| € Anemia |  |
| € Infections (if yes what type and how were they treated) | |

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| **Family History** | | | | | | | | |
| Relationship | Living Y/N | Age | Major Medical Problems and/or Cause of Death | | | | | |
| Father |  |  |  | | | | | |
| Mother |  |  |  | | | | | |
| Siblings |  |  |  | | | | | |
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| Specifically have any of the child's relatives had the following conditions | | | | | | | |
| Condition | | | | Relative |  | Condition | Relative |
| € Diabetes | | | |  | € Kidney problems |  |
| € Cancer | | | |  | € Heart disease |  |
| € Seizures | | | |  | € Stroke |  |
| € Allergies/asthma | | | |  | € Anemia |  |
| € Bleeding problems | | | |  | € HIV |  |
| € High blood pressure | | | |  | € Skin problems |  |
| € Lung disease | | | |  | € Chemical dependency |  |
| € Mental illness | | | |  | € Other: |  |
| Are there any religious or cultural factors that you would like us to take into account when planning your child's healthcare? | | | | | | | |

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| **Newborn History** | | |
| Birth Weight: | Birth length: | Head Circumference: |
| Born on time? € Early € Late How much: | | |
| Type of delivery € Vaginal € C-section (why): | | |
| How old was baby when she/he left the hospital? | | |
| During the first week of life did the patient have any of the following | | |
| € Feeding trouble | € Seizures | € Fever |
| € Excess vomiting | € Breathing trouble | € Receive antibiotics |
| € Jaundice (yellow skin) | € Need of oxygen | € Diarrhea |
| € Cyanosis (blueness) | € Blood transfusion | € In intensive care unit |

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| **Past Medical History** | | |
| Where has child gone for check-ups previously: | | |
| Date of last medical checkup: | | |
| Date of last dental check-up: | | |
| Is your child up-to-date on immunizations? Please supply immunization records. | | |
| Has your child had any of the following | | |
| € Chicken pox | € Wears glasses | € Asthma |
| € Measles | € Heart murmur | € Allergies |
| € Mumps | € Kidney or bladder infection | € Broken bones |
| € Frequent ear infections (>4 year) | € Bed wetting (>5 years old) | € Head injury |
| € Frequent throat infections (>4 year) | € Diabetes | € Seizures |
| Has your child ever been hospitalized or had surgery? If yes, list age and reason: | | |
| Has your child ever been on medication regularly? If yes, list medication(s) and reason: | | |
| Do you have any concerns about your child's development? If yes, please describe: | | |

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| **Allergies** | |
| Please list any allergies to medications or foods | |
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| **Medications** | |
| Please list any medications that your child takes including over the counter medications, herbs, vitamins and supplements. Include dose and frequency | |
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| **Specialty Providers** | |
| In order that we can best coordinate your child's care, please list any medical providers the child sees outside of this practice and list the year that they last saw them | |
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| **Health Literacy Questionnaire** | |
| Many times in healthcare staff and providers use words that are unfamiliar to the general population. Please rate the following questions on a scale of 1 to 10; 1 being strongly disagree and 10 being strongly agree | |
| I feel that I have a thorough understanding of the instructions  that my doctors and nurses give me about my child’s health | 1 2 3 4 5 6 7 8 9 10 |
| I feel that I remember the instructions given to me at my child’s doctor’s office when I get home | 1 2 3 4 5 6 7 8 9 10 |
| I feel that I have a strong understanding of medical language | 1 2 3 4 5 6 7 8 9 10 |

Parent Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_