Confidential Health Questionnaire

Child's Name: _____ Birthdate _____

Name of person completing this form: _____

Relationship to Child:_____Today's Date: _____

Sea View Pediatrics
YOUR NEIGHBORHOOD PEDIATRICIANS
Serving Orange County Since 1973
A member of CHOC Children's Network

1) Who lives at home with child? (Check all that apply)

☐ Mother ☐ Father ☐ Step parent ☐ Guardian ☐ Grandparent ☐ Siblings ☐ Pets (type)_____

2) Is your child adopted? ☐ No ☐ Yes If yes, age at the time of adoption: _____

3) Primary language spoken at home:_____ ***4) Ethnicity:*** _____

5) Does your child attend? Day care : ☐ No ☐ Yes Preschool: ☐ No ☐ Yes Days per week:_____

School: ☐ No ☐ Yes Grade:_____Name of school:_____Performance:_____

6) Does your child participate in any activities outside of school? ☐ No ☐ Yes _____

7) Is your child taking any?

Medications: ☐ No ☐ Yes (please list)

_____

_____

_____

Vitamins: ☐ No ☐ Yes

Supplements: ☐ No ☐ Yes

8) Does your child have any allergies:

Medications: ☐ No ☐ Yes (please list)

_____

Foods: ☐ No ☐ Yes (please list)

_____

Environment: ☐ No ☐ Yes (please list)

(dust, pollen, grass, cats, dogs, bees, etc)

_____

9) When riding in a car, how is your child restrained?

☐ Rear facing car seat ☐ Forward facing car seat ☐ Booster seat ☐ Regular seat belt ☐ None

10) Does anyone smoke at home? ☐ No ☐ Yes If yes: ☐ Indoor or ☐ Outdoors only

11) Is there a pool or spa in the home? ☐ No ☐ Yes If yes, is there a perimeter fence and gate? ☐ No ☐Yes

12) To assess for lead risk, was your home built prior to 1973? ☐ No ☐Yes

13) Are there firearms in the home? ☐ No ☐ Yes

If yes, how are they stored? ☐ with ammunition ☐ without ammunition

14) Are there any social stressors or family problems going on right now?

_____

_____

15) Are there any specific concerns that you wish to discuss at this visit today?

_____

_____

_____

Patient name_____ Date of Birth _____

16) How was the pregnancy and delivery of this child?

☐ Uncomplicated ☐ Complicated by _____

☐ Vaginal Delivery ☐ Cesarean Section (Indication:_____) Breech? ☐ No ☐ Yes

☐ Early (Prior to 37 weeks) How many weeks _____ ☐ On Time (37-42 weeks) ☐ Late (after 42 weeks)

Child's weight at birth_____lbs_____oz. Hospital of birth: _____

17) What type of milk do/did you give your child in the first year?

☐ Breast milk - Until_____months of age ☐ Formula - which one? _____

18) Did your child have any problems during the first months of life?

☐ Feeding problems/reflux ☐ Constipation ☐ Allergies ☐ Jaundice

19) Do you have any concerns about your child's development? ☐ No ☐ Yes (check all that apply)

☐ Speech ☐ Strength/gross motor skills ☐ Coordination/fine motor skills ☐ Socialization ☐ Problem Solving

20) Has your child ever received any developmental therapies, or special services? ☐ No ☐ Yes (check all that apply)

☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy ☐ Behavioral Therapy

21) Has your child ever been hospitalized or had surgery? ☐ No ☐ Yes (If yes, please provide details)

Date Hospital City and State Reason Length of Stay

_____

_____

22) Does your child have any previous, or ongoing problems or concerns? ☐ No ☐ Yes (check all that apply)

☐ Skin problems ☐ Eczema
☐ Asthma ☐ Allergic Rhinitis/hay fever
☐ Diabetes ☐ Serious Injury
☐ Heart murmur ☐ Many ear infections
☐ Many colds ☐ Many sore throats
☐ Hearing problems ☐ Vision problems
☐ Stomach Problems ☐ Constipation
☐ Diarrhea ☐ Kidney/bladder problems
☐ Hernia ☐ Hip/leg/foot problems
☐ Seizures ☐ Bed Wetting
☐ Behavior problems ☐ Sleep problems
☐ School problems ☐ Anemia
☐ Other_____
☐ Other _____

23) Have any members of the family had any of the following conditions? If so, Who?

☐ No ☐ Yes Anemia _____
☐ No ☐ Yes Asthma _____
☐ No ☐ Yes Hay Fever _____
☐ No ☐ Yes Migraines _____
☐ No ☐ Yes Seizures _____
☐ No ☐ Yes Diabetes _____
☐ No ☐ Yes ADHD _____
☐ No ☐ Yes Mental Delay _____
☐ No ☐ Yes Depression/Anxiety _____
☐ No ☐ Yes Birth Defects _____
☐ No ☐ Yes High Blood Pressure _____
☐ No ☐ Yes High Cholesterol _____
☐ No ☐ Yes Other Heart Disease _____
☐ No ☐ Yes Thyroid Disease _____