Alta California Medical Group
2925 N. Sycamore Dr. #204
Simi Valley, CA 93065

PEDIATRIC HISTORY QUESTIONNAIRE

Child's Name:_____
MRN:_____
DOB:_____

Mother's Name:_____ Age:_____ Occupation:_____
Home Phone:_____ Wk Phone:_____ Cell:_____
Father's Name:_____ Age:_____ Occupation:_____
Hm Phone:_____ Wk Phone:_____ Cell:_____
Siblings: (Names/Age):_____ _____
_____ _____

Previous Physician:_____ Provider Comments:

Birth History:

Did mother take any medications, drugs, alcohol, or smoke during pregnancy or at this time: No / Yes
Explain:_____
Were there any problems with the pregnancy: No / Yes
Explain:_____
Was the delivery vaginal/Cesarean/forceps/vacuum: (please circle)
Were there any problems with the birth? No / Yes
Explain:_____
Baby's birth weight:_____ Length:_____
Mother's blood type:_____ Baby's blood type:_____
Are you formula or breast feeding your child? (circle) No / Yes
Has your child had any hospitalizations? No / Yes
Explain:_____
Has your child had any surgeries: No / Yes
Explain:_____
Has your child had any serious or frequent illnesses or injuries? No / Yes
Explain:_____
Does your child have any problems with feeding? No / Yes
Explain:_____
Does your child have any elimination problems? No / Yes
Explain:_____
Does your child seem to be developing normally/ No / Yes
Explain:_____
Does your child use a car seat/seat belt? No / Yes
Is your child exposed to cigarette smoke? No / Yes
Do you have any concerns today? No / Yes
Explain:_____
Does your child have any allergies or has he/she had any vaccine reactions? No / Yes
Explain:_____

Please give the nurse your baby's immunization records.

Please circle any medical problems that run in your family or your spouse's family:

Anemia	depression	genetic problems	kidney problems	sickle cell disease
Asthma	diabetes	hay fever	liver problems	thyroid problems
Birth defects	early deaths	heart problems	mental retardation	tuberculosis
Cancer	eczema	high blood pressure	seizures	

Please explain:_____
Your name:_____ Relationship to patient:_____ Date:_____
Date reviewed:_____ By:_____MD/NP/PA