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

Child's Name:_____

- 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:

_____
__

_____
__

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:

Child's Name: _____

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
_____	_____	_____
_____	_____	_____
_____	_____	_____

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