Mercer Island Pediatrics

PEDIATRIC PATIENT QUESTIONNAIRE

Patient's Name: _____ Date of Birth: _____
Siblings Name: _____ Date of Birth: _____

Past Medical History

Allergies (Medication, Food, Insects, Etc.): _____
Medications/Supplements: _____
Problems during Mom's pregnancy, the birth or newborn period _____
Hospitalizations/Surgeries: _____
Current or past medical problems: _____

Please check any of the following:

- ☐ Vision problems
- ☐ Hearing problems
- ☐ Speech problems
- ☐ Poisoning/ overdose
- ☐ Serious accident
- ☐ Motor delays
- ☐ Learning problems
- ☐ Mental health concerns
- ☐ Concussion/ serious head injury
- ☐ Hay fever or asthma
- ☐ Urinary tract infection
- ☐ Constipation
- ☐ Soiling
- ☐ Anemia
- ☐ Heart murmur

Briefly explain the above concerns; or add any additional information you feel is important about your child's health:

_____

_____

Family History

Has anyone in the patient's family had any of the following?

- ☐ Child is adopted
- ☐ Birth defects/malformations
- ☐ Developmental problems
- ☐ High cholesterol
- ☐ Hip problems at birth
- ☐ Anemia or blood disorder
- ☐ Asthma or wheezing
- ☐ Tuberculosis
- ☐ Seizures
- ☐ Death before 1 year of age
- ☐ Diabetes
- ☐ Vision
- ☐ Hearing Loss
- ☐ Learning problems
- ☐ School problems
- ☐ Eating disorder
- ☐ Mental illness
- ☐ Suicide
- ☐ Alcoholism
- ☐ Substance abuse
- ☐ Cancer
- ☐ Migraine headaches
- ☐ Kidney problems
- ☐ Emotional problems
- ☐ Depression
- ☐ Heart disease or stroke
- ☐ Hyperactivity or attention deficit disorder

Today's Date: _____ Parent/Guardian Signature: _____