

Medical & Developmental Questionnaire

PLEASE COMPLETE ONE FOR EACH CHILD

Child's name _____ Date of birth _____ / _____ / _____

Pregnancy & Birth

Mother's age at birth _____ years
Did mother have any problems during pregnancy? Yes No
Did she take any medications (except vitamins)? Yes No
Was your baby on time? Yes No
List any problems your baby had in the hospital _____

Was your baby adopted? Yes No

Past Medical History

Where has your child gone for check-ups until now? _____
Are immunizations all up-to-date? Yes No
Have there been any reactions to immunizations? Yes No
List any hospitalizations/surgeries (except for birth) _____

List any other serious illnesses _____

List any medications your child takes regularly _____

Family History

Are both parents in good health? Yes No
Check any diseases that occur in your family: Anemia Allergies Asthma Diabetes
 High blood pressure Heart disease High cholesterol Epilepsy
 Cancer Drug/alcohol problems Other _____

Feeding & Nutrition

Was your baby breast-fed? Yes No
If bottle-fed, which formula did you use? _____
Does your child take vitamin supplements? Yes No
Does your child take fluoride supplements? Yes No
Has there been any evidence of food allergy? Yes No

Review of Previous Problems

Check if your child has had... Frequent ear infections Frequent colds or sore throats
 Asthma, pneumonia or recurrent cough, or has used a nebulizer or inhaler
 Heart murmur Problem with urination Chronic constipation or diarrhea
 Convulsions or developmental problems Eczema, hives or rashes

Development & Behavior

At what age did your child walk alone? _____ years _____ months
At what age did your child say his/her first words? _____ years _____ months
Is your child having any problems at school? Yes No
Does your child sleep well? Yes No
Does he/she get along well with other children? Yes No
Check any of these problems your child exhibits... Nail biting Thumb sucking
 Bed wetting Delayed toilet training Hyperactivity Nightmares
 Speech problems Problems with discipline Other: _____

Safety & Environment

Does your child always use a car seat/booster seat/seat belt? Yes No
Do you have smoke alarms in your house? Yes No
Do you have a carbon monoxide alarm in your house? Yes No
Do you know how hot your water gets? Yes No
Do you have the Poison Center phone number at home? Yes No
Does your child always wear his/her helmet when cycling, skiing or skating? Yes No
Are there any smokers in your household? Yes No
Are there any guns in your household? Yes No

WAYNE PEDIATRICS OFFICE USE: Reviewed by _____ Date _____ / _____ / _____