New Pediatric Patient Health Questionnaire

What should we call your child? _____ Birth Date _____

Name of person filling out the form _____ Relationship to Patient _____

Patient's Pronouns *(circle all that apply):* she/her/hers he/him/his they/them/theirs not listed: _____

Patient's Current Gender Identity *(circle all that apply):* girl/woman boy/man transwoman/girl transman/boy nonbinary not listed: _____

Patient's Sex Assigned at Birth *(circle all that apply)* female male intersex not listed: _____

Your answers to the following questions will help us understand your or your child's medical history. Please fill out as much information as possible. If you cannot answer a question or feel uncomfortable answering a question, please leave them blank. Thank you for your help.

Household members

Name	Relationship to child	Birth date	Health problems

☐ Adopted ☐ Foster care ☐ Parents divorced/separated ☐ Joint custody ☐ Single custody

Birth History

Birth weight_____Lbs_____oz	☐ Full term birth	☐ Premature___wks	☐ Vaginal birth	☐ C-section

Hospital Name_____ Hospital City, State _____

☐ Prenatal or neonatal complications: Explain: _____ ☐ NICU stay – How long? _____weeks

☐ Tobacco use in pregnancy ☐ Alcohol use in pregnancy ☐ Medication/drug use in pregnancy

Medical History *(Please check or list any medical problems your child has experienced)*

☐ Problems with hearing or ears	☐ Problems with vision or eyes	☐ Allergies
☐ Asthma or wheezing	☐ Heart murmur or heart disorder	☐ Depression/Anxiety/AHD/or Mood disorder
☐ Headaches/migraines	☐ Kidney disease or recurring UTIs	☐ History of head injury or concussion
☐ Seizures	☐ Substance abuse	☐ Snoring/ Obstructive sleep apnea
☐ Surgeries	Type of surgery/year?	☐ Other

Further explanation any of the above: _____

Family Medical History *(Please check or list any medical problems in your child's biological family)*

Asthma	Who?	☐ Stroke/Cardiovascular disease/Heart attack < age 55y	Who?
☐ Cancer	Who/type?	☐ High cholesterol	Who?
☐ Depression/Anxiety/Mental illness	Who?	☐ Diabetes	Who?
☐ Early sudden death	Who?	☐ Substance abuse	Who?
☐ High blood pressure	Who?	☐ Childhood hearing loss	Who?
☐ Other	What/Who?		

Other family history/explanations: _____

PLACE PATIENT LABEL HERE

Physical Activity

On average, how many days per week does your child engage in moderate to strenuous exercise (like walking fast, running, jogging, dancing, swimming, biking, weightlifting or other activities that cause a light or heavy sweat)?	0 1 2 3 4 5 6 7
On average, how many minutes does your child engage in exercise at this level?	0 10 20 30 40 50 60 70 80 90 >90

Medications and supplements *(Please list medications, vitamins, & supplements you take, dose, and condition for which you take them)*

Medication or supplement	Dose and how often taken	Condition

Medication Allergies *(Please list the name of the medication and the reaction you experienced. If necessary, turn paper over for additional lines.)*

Medication	Reaction

Other Health Care Providers *(Please list your child's previous doctor and any other specialists (e.g., allergists, counselors, etc.) that care for your child.)*

Doctor's/Care Provider's Name	Type of physician/specialty and Location

Household Members Overflow

Name	Relationship to child	Birth date	Health problems

Medications and supplements overflow *(Please list medications and supplements you take and what for what condition you take them)*

Medication or supplement	Dose and how often taken	Condition

PLACE PATIENT LABEL HERE

Medication Allergies Overflow *(Please list the name of the medication and the reaction you experienced)*

Medication	Reaction

Other Health Care Providers *(Please list your child's previous doctor and any other specialists (e.g. allergists, cardiologists, etc.) that care for your child.)*

Doctor's/Care Provider's Name	Type of physician/specialty and Location

Any additional comments/information you would like to include:

PLACE PATIENT LABEL HERE