Baptist Primary Care Pediatric Questionnaire (Ages 4-16)

Name: _____ Date of Birth: _____ Today's Date: _____

Have you provided the office with the most up to date insurance card, driver's license, address, and phone number(s)?

What is the purpose of today's visit? (please list all symptoms)

_____

_____

_____

_____

Please list all known medication/food allergies: (medication and the reaction)

_____

_____

Medications (prescriptions, vitamins, over the counter, herbal remedies.)

Name	Strength	How often per day?	Reason for taking?

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

Name: _____ Date of Birth: _____

Previous Medical History:

_____

_____

_____

Birth History:

Complication during birth:_____

Premature: ☐ Yes ☐ No

Complications after birth: _____

Family History (please list immediate family member affected)

☐ Depression/Anxiety:_____ ☐ Asthma:_____

☐ Cancer (type): _____ ☐ Diabetes: _____

☐ Seizures: _____ ☐ Arthritis: _____

☐ Tuberculosis: _____ ☐ Stroke: _____

☐ Heart Disease/Attack:_____ ☐ High/Low Blood Pressure:_____

☐ Kidney Stones/Disease:_____ ☐ Cholesterol: _____

☐ Osteoporosis: _____ ☐ Thyroid Disorder: _____

☐ Alcohol/Drug Use: _____ ☐ Skin Disorders:_____

☐ Other: _____

Immunization History (please list last known date of immunization): Tetanus_____ HPV_____ MMR_____

Flu_____ Tetanus_____ Hepatitis A_____ Hepatitis B _____ Polio_____

Preventative Health:

Seat Belts: ☐ Yes ☐ No

Glasses/Contacts: ☐ Yes ☐ No

Developmental/Social: Do you feel that your child is/was slow in his/her development:

Speech/Language: ☐ Yes _____
☐ No

Social Skills: ☐ Yes _____
☐ No

Motor Skills: ☐ Yes _____
☐ No

Surgical and Hospital Past Medical History

Date	Reason for Surgery/Hospitalization

Name of Specialists	***Reason for seeing Specialist***

_____

Patient's Signature Date

_____

Reviewer Signature Date