Marion Pediatrics, PA
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PARENT QUESTIONNAIRE

Patients Names:_____ DOB: _____

Allergies: _____ Immunizations:_____

Mother's Name:_____ Age: _____ DOB: _____

Father's Name:_____ Age: _____ DOB: _____

Sibling(s) Name(s) and Ages(s): _____

_____

Previous/Referring Physician: _____

Medications: Please list current medications prescribed and over the counter your child is taking _____

_____

PAST MEDICAL HISTORY: Please indicate any history of any of the following medical conditions

- ☐ Abdominal Pain
- ☐ Acne
- ☐ ADD/ADHD
- ☐ Allergic Rhinitis
- ☐ Anemia
- ☐ Asthma
- ☐ Autism
- ☐ Bed Wetting
- ☐ Behavioral Problems
- ☐ Bone Fracture (Broke n Bone)
- ☐ Chickenpox
- ☐ Cleft Palate
- ☐ Concussion
- ☐ Constipation
- ☐ Convulsions
- ☐ Depression
- ☐ Diabetes Type I (juvenile)
- ☐ Ear Infection, Chronic
- ☐ Eczema
- ☐ Elevated Blood Pressure
- ☐ Eyes or Vision Problems
- ☐ Gastroesophageal Reflux
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hydrocephalus, Congenital
- ☐ Hypertension
- ☐ Kidney Infection
- ☐ Medical History Unknown
- ☐ Oral Thrush
- ☐ Other
- ☐ Seizure Disorder
- ☐ Sickle Cell Anemia
- ☐ Sleep Disturbance
- ☐ Thyroid Disorder
- ☐ Whooping Cough

PAST SURGICAL HISTORY: Please indicate child's past history of any of the following surgical procedures

- ☐ Adenoid Removal
- ☐ Appendectomy
- ☐ Broken Bones (surgery required)
- ☐ Circumcision
- ☐ Cleft Palate Repair
- ☐ Ear Tube Insertion
- ☐ Heart Surgery
- ☐ Hernia Repair
- ☐ Other
- ☐ Surgical History Unknown
- ☐ Tonsillectomy

FAMILY HISTORY: Please indicate any family history of any of the following medical conditions with **M** for Maternal (mother), **P** for Paternal (father) or **B** for Both

- ☐ ADD/ADHD
- ☐ Alcohol Abuse
- ☐ Anemia
- ☐ Asthma
- ☐ Autistic Disorder
- ☐ Bed Wetting
- ☐ Behavioral Problems/Mental Illness
- ☐ Blindness
- ☐ Cancer
- ☐ Chickenpox
- ☐ Cystic Fibrosis
- ☐ Deafness
- ☐ Depression
- ☐ Diabetes Mellitus, Type Ii
- ☐ Diabetes Type I (juvenile type)
- ☐ Down Syndrome
- ☐ Drug Abuse
- ☐ Epilepsy
- ☐ *Family History Unknown*
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ HIV
- ☐ Hypercholesterolemia
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Retardation
- ☐ Migraine Headaches
- ☐ Other
- ☐ Seizure Disorder
- ☐ Sudden Infant Death Syndrome
- ☐ Sudden Unexplained Death
- ☐ Tuberculosis Infection

SOCIAL HISTORY: Please indicate any of the following:

- ☐ Exposed to cigarette/cigar smoking
- ☐ Child living with other caregiver
- ☐ Father Living in Home
- ☐ Foster Child
- ☐ Housing
- ☐ Mother Living in Home
- ☐ Smokes Current Everyday
- ☐ Never Smoked
- ☐ Parents Divorced
- ☐ Parents Married
- ☐ Parents Separated
- ☐ Pets in Home
- ☐ Plays Team Sport
- ☐ Plays Video Game <1 hr per Day
- ☐ Smokes Current some days
- ☐ Smoking Status Unknown
- ☐ Plays Video Game >1 hr per Day
- ☐ Sedentary
- ☐ Sibling(s) Living at Home
- ☐ Significant Other Living at Home
- ☐ Watches Television > 1 Hr Per Day
- ☐ Watches Television < 1Hr Per Day
- ☐ Former Smoker

PAST HISTORY:

1. Gestational Age: _____

   Hospital:_____

   Type of Delivery: _____

   Birth Weight: _____ Any Complications:_____
2. Developmental Milestones: Crawled at_____ Walked at _____ First Words said at _____
3. Water Supply City Well (please circle)
4. School Attending:_____
5. Grade Level_____ Grade Average: _____
6. Favorite Sport: _____ Extracurricular Activities:_____

Parent/Guardian _____ Date: _____