Sheboygan Pediatrics
FROM CRADLE TO COLLEGE

Sheboygan Pediatric Associates, S.C.
2920 Superior Avenue
Sheboygan, WI 53081
PH: 920-458-3331
www.sheboyganpeds.com

PATIENT HISTORY QUESTIONNAIRE

Date: _____

Name: _____ DOB: _____ Referred By: _____

BIRTH HISTORY

Was this child? Full term _____ Pre-term _____ Adopted _____

If pre-term, how many weeks? _____ If adopted, at what age? _____

Type of delivery? Vaginal _____ C-section _____ If C-section, why? _____

Birth weight _____ Breech _____ Birth length _____ Birth Head Circ. _____

Breast or Bottle fed? _____ Passed hearing screen? _____

PATIENT HISTORY

Current problems/concerns: _____

Allergies (Medications, Vaccines, Food, Other): _____

Current Medications: _____

Has your child:

- Ever been hospitalized? No/Yes - _____
- Ever needed emergency treatment? No / Yes - _____
- Ever had surgery? No / Yes - _____

	Yes	No
ADD/ADHD		
Allergies		
Asthma		
Cancer		
Chronic encephalopathy		
Diabetes mellitus		
Eczema		
Headaches		
Hearing loss		

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Medical History - Continued	Yes	No
Heart Murmur		
HIV/AIDS		
Inflammatory bowel disease		
Jaundice		
Lead poisoning		
Meningitis		
Obesity		
Otitis Media		
Pneumonia		
Scoliosis		
Seizures		
Sickle cell anemia		
Strep throat (recurrent)		
UTI		
Varicella		
Vision problems		
Serious injury or concussion		
Developmental and/or speech problems		
For girls only, has she started her menstrual cycle?		

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FAMILY HISTORY QUESTIONNAIRE

Date: _____

Person Filling Out This Form: _____ Relationship to Child: _____

Child #1: _____ M / F D.O.B. _____

Child #2: _____ M / F D.O.B. _____

Child #3: _____ M / F D.O.B. _____

Child #4: _____ M / F D.O.B. _____

Child #5: _____ M / F D.O.B. _____

Please check where child's blood relatives have any of these problems.

Condition	**Which relative?** Please specify if relationship is maternal (mother's side) or paternal (father's side) -- *i.e. materal cousin, paternal grandfather..*
High Blood Pressure	
High cholesterol	
Prolonged QT	
Early heart attack (under 50 yrs. Old)	
Sudden unexplained death	
Anemia	
Bleeding or clotting disorder	
Allergies	
Autoimmune disorder	
Cancer	
Development/genetic disease	
Diabetes	
Thyroid Disease	
Polycystic Ovarian Syndrome (PCOS)	
Ear tubes	
Deafness	
Stomach problems	
Liver disease	
Celiac disease	
ADD/ADHD	
Migraines	
Autism	
Seizures	
Mental illness	
Drug/alcohol abuse	
Asthma	
Tuberculosis	
Kidney problems	
Lazy eye	
Hip dysplasia	
Other	

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SOCIAL HISTORY QUESTIONNAIRE

Date: _____

Patient Name: _____ DOB: _____

Address: _____ City _____ State _____ Zip _____

Father's Name: _____ DOB: _____

Address: _____ City _____ State _____ Zip _____

Employer: _____ Occupation: _____

Home phone: _____ Work phone: _____ SS# _____

Mother's Name: _____ DOB: _____

Address: _____ City _____ State _____ Zip _____

Employer: _____ Occupation: _____

Home phone: _____ Work phone: _____ SS# _____

Social History

Who lives in your child's home? _____

_____

If parents are not living together or if child does not live with parents, what is the child's custody status?

_____

Is your child in: Daycare? _____ School? _____ If so, what grade? _____ Are there any household members that smoke in the home? _____

Are there any lead concerns in your home? (i.e., older home, chipping paint) _____

Do you have any concerns about your child's school performance? _____

_____

Is there anything more you would like us to know about your child? _____

_____

Form Completed by: _____ **Relationship to child:** _____