Warwick PEDIATRICS
THE OFFICE OF
DOMINIC BERLINGIERI, MD, FAAP

PEDIATRIC HISTORY QUESTIONNAIRE

Child's Name _____ Today's Date_____
Birth Date _____ Age _____
Address: _____
Phone: _____ Primary Insurance:_____ Secondary Ins: _____

Responsible Parties:

Father/Guardian: _____Age: _____Occupation:_____
Date of Birth: _____ Soc Sec #: _____ Cell Phone: _____
Mother/Guardian:_____Age:_____Occupation:_____
Date of Birth:_____ Soc Sec #:_____ Cell Phone: _____
Are natural parents living together in household:_____
If not, where?_____

Other people living in household:

	Name	Age
Brothers		
Sisters		
Others		

What was baby's due date?_____ Type of delivery: Vaginal _____ C-Section _____
Birth Weight _____ Length _____ Apgar Scores _____

Please check correct response:	Yes	No	Explain (use reverse side of form, if needed)
Any medical problems during pregnancy?	( )	( )	_____
Did mother do any of the following during pregnancy? Smoke	( )	( )	_____
Drink alcohol	( )	( )	_____
Use drugs	( )	( )	_____
Did baby have any problems in nursery?	( )	( )	_____
Any problems during the first month of life?	( )	( )	_____
Did mother have any problems during pregnancy? (i.e. problems with spouse, job, money, living arrangements)	( )	( )	_____ _____

List all hospitalizations, major illnesses, accidents, broken bones:

Date	Child's Age	Name of Hospital	Reason for Hospitalization
_____	_____	_____	_____

Any allergies to food or medication? Yes _____ No _____
If yes, please list them _____
List child's present medicines including vitamins and fluoride_____
Child's previous physician(s)?_____
Do you have a record of the child's immunization's? Yes _____ No _____ (Please provide a copy)

Child's Development History

1. While child was growing up, or at present, have you noticed any difficulties in these areas?

	Yes	No	Age (years & months) when accomplished & comments)
a. Walking alone	( )	( )	_____
b. Speaking phrases (two words together)	( )	( )	_____
c. Bowel training	( )	( )	_____
d. Bladder training	( )	( )	_____

Has your child ever been diagnosed with a delay in developmental? _____
If yes, please state delay and provide any evaluations your child has had:_____

2. While the child was growing up, or at the present, have you noticed any difficulties in these areas?

	Yes	No	Age when difficulties became apparent & comments
a. Temper tantrums	( )	( )	_____
b. Fighting	( )	( )	_____
c. Difficulty making friends	( )	( )	_____
d. Academic problems	( )	( )	_____
e. Actively defies adult rules	( )	( )	_____
f. Anxiety / Nervousness	( )	( )	_____
g. Missing school	( )	( )	_____
h. Running away	( )	( )	_____

Social History:

If in school, present grade? _____
What does child do in spare time? _____
How many hours a day does child watch TV? _____
Indicate any financial, interpersonal or family problems you are worried about _____
_____
_____
Are there guns in the home?_____
Does anyone in the home smoke?_____
Are there pets in the home? _____
Has child ever had counseling? _____

Family History:

Check any of the following problems and which relatives have them (including natural parents, siblings, aunts, uncles and grandparents):

Eczema _____
Seizure disorder _____
Tuberculosis _____
Allergies _____
Asthma _____
High Blood Pressure _____
Heart attack, stroke (under 55 yrs of age) _____
Diabetes _____
Obesity _____
High cholesterol or Triglycerides _____
Legal problems _____

Anemia _____
Alcoholism / drug abuse _____
Kidney disease _____
Cystic fibrosis _____
Cancer _____
Mental retardation _____
Birth defects _____
Emotional problems _____
Death before 50 yrs of age, other then accident _____
Domestic violence _____
Behavioral problems _____
Learning problems _____

Review of Systems (has your child had any of the following):

( ) Skin trouble
( ) Eye problems
( ) Frequent ear infections
( ) Difficulty hearing
( ) Frequent nose bleeds
( ) Frequent sore throats
( ) Pneumonia
( ) Any other lung problems
( ) Heart Murmur
( ) Jaundice
( ) Frequent stomach aches
( ) Frequent diarrhea
( ) Frequent constipation
( ) Black stool
( ) Kidney or bladder infection
( ) Painful urination
( ) Bedwetting
( ) Painful periods
( ) Anemia
( ) Joint aches or pains
( ) Loss of consciousness
( ) Seizures
( ) Frequent headaches
( ) Behavioral problems
( ) Rheumatic fever
( ) Measles
( ) Chicken Pox
( ) Mumps
( ) Rubella
( ) Whooping cough
( ) Hepatitis
( ) Other _____
_____

Any additional comments: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

This form completed by: _____

Relationship to child: _____

_____ _____
Reviewed by: (MD, NP, PA) Signature Date