

CHILD PATIENT QUESTIONNAIRE HISTORY



DATE: _____

NAME: _____ AGE: _____

REFERRED BY: PHYSICIAN _____ SELF FRIEND YELLOW PAGES OTHER

CHIEF COMPLAINT: _____

SOCIAL HISTORY: (REVIEWED & NON-CONTRIBUTORY)

SCHOOL: YES NO GRADE _____ SIBLINGS: YES NO # _____

NUTRITIONAL HISTORY:

Artificial Dye (kool-aid, punch, frozen pops, etc.) Number per day: _____

Caffeine (Cola, Tea, Chocolate, Coffee) Number per day: _____

GENERAL HEALTH: Good Fair Poor

ALLERGIES: _____

PAST MEDICAL HISTORY:

BIRTH HISTORY: PRE-TERM (# Weeks _____) FULL TERM VAGINAL C-SECTION

IMMUNIZATIONS CURRENT: YES NO

SERIOUS ILLNESSES: _____

OPERATIONS / SURGERIES: _____

FAMILY MEDICAL HISTORY: (i.e. Cancer, Heart Disease, Diabetes)

MOTHER: _____ BROTHERS: _____

FATHER: _____ SISTERS: _____

REVIEW OF SYSTEMS:

Childhood Illnesses:

Measles? No Yes
Mumps? No Yes
Rubella? No Yes
Chicken Pox? No Yes

Gastrointestinal:

Appetite? Good Fair Poor
Food Habits? Good Fair Poor
Diarrhea? No Yes
Constipation? No Yes

Muscular and Skeletal:

Neck / Back Pain No Yes
Neck / Back Injuries No Yes
Scoliosis? No Yes
Multiple Sclerosis? No Yes

Cardiovascular and Respiratory:

Heart Disease? No Yes
High Blood Pressure? No Yes
Chest Pain? No Yes
Cough? No Yes
Asthma? No Yes

REVIEW OF SYSTEMS (cont'd)

Hematology:

Anemia? No Yes
Bleeding Disorder? No Yes
Recent Aspirin? No Yes

Neurological:

Seizures? No Yes
Headaches? No Yes
Psychiatric Problems? No Yes

Endocrine:

Diabetes? No Yes
Thyroid? No Yes

GU REVIEW OF SYSTEMS:

No Yes Burning? _____
 No Yes Urgency? _____
 No Yes Frequency? _____ Number of times per day?
 No Yes Back Pain? _____
 No Yes Kidney Stone? _____
 No Yes Blood in Urine? _____
 No Yes Bladder Spasms? _____
 No Yes Bladder Infections? _____
 No Yes Painful Urination? _____
 No Yes Does your child get up at night to urinate? _____ Number of times per night?

Does your child have "accidents", wets him / herself? Yes No

Does your child "wet the bed"? Yes No

At what age was child potty trained? _____

Does your child know before he / she wets him / herself? Yes No

Does it come without warning? Yes No

Does your child wet immediately after voiding? Yes No

Has your child had any trauma to his / her bladder or private parts? Yes No

If yes, describe: _____

