BLOOMFIELD PEDIATRIC CARE
43205 Woodward Avenue
Bloomfield Hills, MI 48302
(248) 451-0600
Fax (248) 451-0700

GENERAL HEALTH QUESTIONNAIRE

PATIENT'S NAME _____ **D.O.B.**_____

A. HEALTH CARE STATUS

1. Where has your child gone for checkups until now? _____
2. What is the date of your child's last checkup? _____
3. What is the date of your child's last dental checkup? _____
4. Is your child under treatment now for an illness or medical condition? Yes No
   If yes, for what? _____
   With whom? _____
5. Has your child had allergic reactions to any medications, food or bee stings? Yes No
6. Has your child had reactions to any immunizations? Yes No
   If yes, please list: _____
7. Any hospitalizations other than birth? Yes No
   If yes, please list: _____
8. Does you chills take any medications regularly, including over the counter medications such as Tylenol or vitamins? Yes No
   If yes, please list: _____

B. PREGNANCY AND BIRTH

1. Mother's age at birth of this child. _____
2. Did mother have any illnesses during this pregnancy? Yes No
3. Did mother use any medications other than vitamins / iron? Yes No
4. Was the baby born on time? Yes No
5. What was the baby's birth weight? _____
6. Did the baby have any trouble starting to breathe? Yes No
7. Did the baby have any trouble in the hospital? Yes No
   (Jaundice, infections, other?) What kind? _____

C. FAMILY HISTORY

1. Are the child's parents in good health? Yes No
2. Circle any diseases that this child's parents, grandparents, brothers, sisters, aunts, uncles have had:
   Anemia Asthma Allergies AIDS Alcohol Problems Cancer Diabetes Tuberculosis
   High Blood Pressure Heart Trouble Drug Problems Mental Illness Inherited Illness
3. List general health, age and sex of brothers and sisters
   _____
   _____
4. Have any of your children died?

D. FEEDING AND NUTRITION

1. Is your child's appetite usually good? Yes No
2. Is it good now? Yes No
3. Was there severe colic or unusual feeding issues during first 3 months of life? Yes No
4. Do any foods disagree with your child? Yes No
5. Is/was your child **Breast** or **Bottle Fed** or **Both** ? (circle one)
6. If still on formula, which one do you use? _____
7. Does your child take vitamins? Yes No

E. REVIEW OF SYSTEMS

1. Has your child had frequent ear infections? Yes No
2. Has your child had any eye or vision problems? Yes No
3. Has your child had any problems with their teeth? Yes No
4. Does your child have frequent colds or sore throats? Yes No
5. is there asthma, pneumonia or a recurrent cough? Yes No
6. Does your child have a heart murmur or any heart problems? Yes No
7. Any problems with urination? Yes No
8. Any problems with diarrhea or constipation? Yes No
9. Have there been any convulsions or other problems with the nervous system? Yes No
10. Any eczema, hives or other skin conditions? Yes No
11. Has your child ever been anemic? Yes No
12. Please list any other medical problems _____

_____

F. DEVELOPMENT / BEHAVIOR

1. At what age did your child sit alone? _____
2. At what age did your child walk alone? _____
3. Did your child say any words by the time he / she was 1 ½ years old? Yes No
4. How does your child compare to other children his or her age?

_____

5. Does your child have trouble sleeping? Yes No
6. What grade is your child in? _____
7. Does your child get along with other children? Yes No
8. Circle if your child has any of the following:

   Nail Biting Thumb Sucking Bed Wetting Problems with Toilet Training Bad Temper
   Hyperactivity Nightmares Speech Problems Discipline Problems Other _____

G. SAFETY / ENVIRONMENT

1. Does the child ride in a car seat or always use a seat belt? Yes No
2. Do you live a private house, apartment, mobile home, other? (circle one)
3. Is your home regularly inspected for health hazards such as peeling paint, insects, rats, or mice? Yes No
4. Do you forbid smoking in your house? Yes No
5. Have any of the child's caregivers been trained in CPR? Yes No

H. IMMUNIZATIONS

1. Do you have a record of vaccines that this child has received? Yes No

   If yes, please give immunization record to nurse with this form.

LIST ANY OTHER QUESTIONS OR CONCERNS FOR THE DOCTOR

_____

_____

_____

NAME OF PERSON COMPLETING FORM: _____

RELATIONSHIP _____ **DATE** _____

PHYSICIANS SIGNATURE _____ **DATE** _____