SNAHC
Sacramento Native American Health Center
a californiahealth+center

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# Patient Questionnaire for Pediatrics (ages 17 and under)

Note: This information is confidential and will be reviewed by the provider. The information will be used to update your medical record.

Name: _____ DOB: _____ Today's Date: _____

Parents/Guardians: _____ Contact Info: _____

School:_____ Grade: _____

Current Insurance: _____ Last Pediatrician/Provider: _____

Preferred Pharmacy _____

How did you hear about us? ☐ Friend or family ☐Health Plan ☐ Social Media ☐ Other_____

## CHILD'S BIRTH HISTORY

Is your child yours by ☐ Birth ☐ Adoption ☐ Foster Care ☐ Other _____

Birthplace: _____

Delivery: ☐ Vaginal ☐ Cesarean ☐ Forceps ☐ Vacuum ☐ Trauma (please check all that apply)

Any birth complications: _____

Was the delivery ☐ On Time ☐ Before 37 weeks of pregnancy ☐ After 42 weeks of pregnancy

Birth Weight:_____

Birth Length: _____

Did your child breastfeed? ☐ Y ☐ N Until what age: _____

Any breastfeeding problems? ☐ Y ☐ N _____

Did the mother have any problems or illness during pregnancy? ☐ Y ☐ N If Yes, Explain:

_____

## MEDICATIONS - Please list all medications your child takes and their dosages, either prescription or over the counter.

☐ **None**

| Medication | Dose | Medication | Dose |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

## IMMUNIZATIONS

Is your child current on his/her immunizations? ☐ Y ☐ N ☐ Not sure

## ALLERGIES – Is your child allergic to or had a reaction to any of the following? Check each that apply.

☐ Food (such as shellfish, nuts, etc.) If yes, what? _____
☐ Medications (such as antibiotics or pain medicine) If yes, which? _____
☐ Latex
☐ Animals
☐ Local anesthetic
☐ Other allergies you need to tell us about? If so, what? _____

## ILLNESS/INJURY – Does your child have now or in the past any of the following conditions:

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Chicken Pox | ☐ | ☐ | Heart problems or murmur |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Abdominal bleeding or pain |
| ☐ | ☐ | Recurrent Ear Infections | ☐ | ☐ | Anemia or Bleeding Problem |
| ☐ | ☐ | Problem with ears or hearing | ☐ | ☐ | Frequent Abdominal Pain |
| ☐ | ☐ | Problems with eyes or vision | ☐ | ☐ | Constipations requiring a doctor visit |
| ☐ | ☐ | Frequent Headaches | ☐ | ☐ | Bladder, Urinary Tract or Kidney Infection |
| ☐ | ☐ | Asthma | ☐ | ☐ | Bed-Wetting (if over 5 years old) |
| ☐ | ☐ | Croup | ☐ | ☐ | ADHD/ADD |
| ☐ | ☐ | Bronchitis or pneumonia | ☐ | ☐ | Depression or Anxiety |
| ☐ | ☐ | Thyroid problem | ☐ | ☐ | Seizures/ Other Neurological Issues |
| ☐ | ☐ | Chronic or Recurrent Skin Problems | ☐ | ☐ | Learning disabilities |
| ☐ | ☐ | Accidents/broken bones | ☐ | ☐ | Other _____ |
| ☐ | ☐ | (Girls) Started menstruating | | | |
| ☐ | ☐ | (Girls) Problems with periods | | | |

## SURGERIES – Please list all surgeries or hospitalizations your child has had.

| SURGERY: | Date and Location of Surgery: | Complications: |
|---|---|---|
| | | |
| | | |
| **HOSPITALIZATION:** | **Date & Location of Hospitalization(s)** | **Reason for Admission(s):** |
| | | |
| | | |

## FAMILY HISTORY – Have any of your child's family members had any of the following conditions?

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Diabetes | ☐ | ☐ | Cancer | ☐ | ☐ | Hepatitis/liver problem |
| ☐ | ☐ | High blood pressure | ☐ | ☐ | Mental/emotional problem | ☐ | ☐ | Inherited disorders |
| ☐ | ☐ | Heart Disease | ☐ | ☐ | Alcohol/drug problem | ☐ | ☐ | Gastrointestinal problem |
| ☐ | ☐ | Congenital heart defects | ☐ | ☐ | Thalassemia or Sickle cell | ☐ | ☐ | Kidney or urine problem |
| ☐ | ☐ | Stroke | ☐ | ☐ | TB or lung problems | ☐ | ☐ | Other |

_____

## FAMILY LIFE

Name and ages of Siblings

_____ _____ _____ _____

What adults live with your child?

_____ _____ _____ _____

What types of pets do you have? _____

Does anyone smoke in the house? ☐ Y ☐ N Do you have a gun or firearm in the house? ☐ Y ☐ N

How many hours of TV/phone/computer games does your child watch on a typical day? _____

Favorite Activities _____

Has your child suffered trauma or loss? ☐ Y ☐ N _____

Do you feel like your child's home is safe? ☐ Y ☐ N _____

## NUTRITION/ORAL HEALTH

Does your child have any Nutritional Problems? ☐ Y ☐ N

Do you feel your family has enough to eat? ☐ Y ☐ N

When did your child last see a dentist? _____

Is your child taking fluoride? ☐ Y ☐ N

Circle what your child eats on a typical day:

| | | | |
|---|---|---|---|
| Breast Milk | Cereal/Bread/Pasta | Cheese/Dairy products | Soda/Energy drinks |
| Formula | Rice/Grains | Fruit | Fast food |
| Meat | Fruit Juice | Vegetables | Snack foods/Chips |
| Beans | Skim Milk | Vitamins | Other _____ |
| Eggs | Whole Milk | Chocolate/Candy | |

## SCHOOL-AGED CHILDREN

**Yes No**

☐ ☐ Has your child ever been "held back" or had to repeat a grade?
☐ ☐ Are you concerned about your child's attention span?
☐ ☐ Does your child like school?
☐ ☐ Any concerns about your child's behavior in school?
☐ ☐ Any concerns about how he/she is doing academically?

***The above information is true and accurate to the best of my recollection.***

**Parent/Guardian Signature: _____**

**Date: _____**

***The above information is true and accurate to the best of my recollection.***

**Patient Signature: _____**

**Date: _____**

**Provider Name: _____Signature: _____ Review Date:_____**

Name _____ DOB _____ HRN _____