NORTHWEST SUBURBAN PEDIATRICS, S.C.
GROW WITH US

HEALTH QUESTIONNAIRE

Patient Name _____ Date of Birth _____/_____/_____

Please complete the following as best you can prior to visit:

A. PREGNANCY & BIRTH

1. Any problems with the pregnancy, labor or delivery? Yes _____ No _____ Delivery (Please circle): Vaginal Cesarean
2. Was the baby premature? Yes _____ No _____
   If yes, how many weeks was the pregnancy? _____Weeks
3. Birth weight _____ lbs. _____oz
4. Was the baby breech? Yes _____ No _____
5. Did your baby have any medical problems while in the hospital as a newborn? Yes _____ No _____
   Please explain _____
6. Did the baby stay in the hospital longer than the mother? Yes _____ No _____
   If yes, why? _____

B. PAST MEDICAL HISTORY

1. Has your child ever been hospitalized? Yes _____ No _____
2. Any surgeries? Yes _____ No _____
   If yes, describe _____
3. Any allergies to foods or medication? Yes _____ No _____
   If yes, please explain _____
4. Is your child currently on medication? Yes _____ No _____
   If yes, please list _____
5. Any serious accidents, broken bones, stitches? Yes _____ No _____
   If yes, please explain _____
6. Any chronic medical problems e.g. asthma, allergies, diabetes, seizures,
   cystic fibrosis, urinary tract infection, ear infections? Yes _____ No _____
   Please explain _____

C. IMMUNIZATIONS

If you have your child's immunization records, please give it to the nurse or receptionist.

1. Is your child behind on his or her immunizations? Yes _____ No _____
   Please explain _____
2. Any previous reactions to immunizations? Yes _____ No _____
   Please explain _____

D. FEEDING

1. Was the baby breast fed or bottle fed? _____
   If breast fed, for how long? _____
2. Is your child still on a bottle? Yes _____ No _____

E. SOCIAL

1. Is your child in daycare? Yes ___ No _____
2. Does anyone in your home smoke? Yes _____ No _____
3. Do you have any firearms in your home? Yes _____ No _____
   If yes, are they locked and unloaded? Yes _____ No _____
4. Do you live or visit regularly a house built before 1978 (including daycare)? Yes _____ No _____
5. Do you have pets at home? Yes _____ No ____
   If so, what kind: _____
6. Do members of the household travel to foreign countries? Yes _____ No _____
   If so, name the countries: _____
7. Who lives at home with your child? _____

F. DEVELOPMENT & GENERAL MANAGEMENT

1. Do you have any problems managing your child? Yes _____ No _____
2. Does your child have any difficulties in school? Yes _____ No _____
3. Is your child in a special class? Yes _____ No ____
4. What grade is your child in? _____
5. Have you been concerned with your child's development? Yes _____ No _____

G. FAMILY HISTORY

1. Does anyone in the family blood-related to your child (siblings, biologic parents of your child, grandparents, aunts, uncles, first cousin) have the following medical problems?

Please circle

STROKES	ASTHMA	CANCER
SEIZURES	BEDWETTING	DIABETES
BIRTH DEFECT	TUBERCULOSIS	DEPRESSION
EARLY DEATHS	THYROID PROBLEMS	HIGH CHOLESTEROL
RHEUMATIC FEVER	HEART DISEASE	HAY FEVER / ALLERGIES
SUBSTANCE ABUSE	CHILDHOOD HIP PROBLEMS	HIGH BLOOD PRESSURE
HEART ATTACKS BEFORE AGE 50	ATTENTION DEFICIT DISORDER	OTHER HEART PROBLEMS

2. Does the child's mother have any health problems? Yes ___ No _____
   If yes, explain _____
   _____
3. Does the child's father have any health problems? Yes ___ No ____
   If yes, explain _____
   _____
4. Has either parent ever had any serious illness? Yes _____ No _____
   If yes, explain _____
   _____
5. List ages, sex, and general health of your child's brothers and sisters:

   _____
   _____
   _____
   _____

THANK YOU

Parent Signature _____ Date: _____ / _____ / _____

POS Reorder # 1612037