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| **Pediatric Health History Questionnaire:****Seaside Wellness of Shallotte** |
| Child's name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Mother's name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Father's name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Siblings names and ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **Pregnancy and Birth History** |
| Mother's age at birth: | Father's age at birth: |
| Did mother have any of the following during pregnancy? |
| € Fever or rash  | € Tobacco use (how much)  |
| € Group B strep  | € Alcohol use (how much)  |
| € Sugar in urine / diabetes  | € Street drug use (what type)  |
| € High blood pressure  | € Medication use (prescription or over-the-counter - list below)  |
| € Anemia  |   |
| € Infections (if yes what type and how were they treated) |

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| **Family History** |
| Relationship | Living Y/N | Age | Major Medical Problems and/or Cause of Death |
| Father |   |   |   |
| Mother |   |   |   |
| Siblings |   |   |   |
|   |   |   |   |
|   |   |   |   |
| Specifically have any of the child's relatives had the following conditions |
| Condition | Relative |   | Condition | Relative |
| € Diabetes |   | € Kidney problems |   |
| € Cancer |   | € Heart disease |   |
| € Seizures |   | € Stroke |   |
| € Allergies/asthma |   | € Anemia |   |
| € Bleeding problems |   | € HIV |   |
| € High blood pressure |   | € Skin problems |   |
| € Lung disease |   | € Chemical dependency |   |
| € Mental illness |   | € Other: |   |
| Are there any religious or cultural factors that you would like us to take into account when planning your child's healthcare? |

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| **Newborn History** |
| Birth Weight: | Birth length: | Head Circumference: |
| Born on time? € Early € Late How much: |
| Type of delivery € Vaginal € C-section (why): |
| How old was baby when she/he left the hospital? |
| During the first week of life did the patient have any of the following |
| € Feeding trouble | € Seizures | € Fever |
| € Excess vomiting | € Breathing trouble | € Receive antibiotics |
| € Jaundice (yellow skin) | € Need of oxygen | € Diarrhea |
| € Cyanosis (blueness) | € Blood transfusion | € In intensive care unit |

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| **Past Medical History** |
| Where has child gone for check-ups previously: |
| Date of last medical checkup: |
| Date of last dental check-up: |
| Is your child up-to-date on immunizations? Please supply immunization records. |
| Has your child had any of the following |
| € Chicken pox | € Wears glasses | € Asthma |
| € Measles | € Heart murmur | € Allergies |
| € Mumps | € Kidney or bladder infection | € Broken bones  |
| € Frequent ear infections (>4 year) | € Bed wetting (>5 years old) | € Head injury |
| € Frequent throat infections (>4 year) | € Diabetes | € Seizures |
| Has your child ever been hospitalized or had surgery? If yes, list age and reason: |
| Has your child ever been on medication regularly? If yes, list medication(s) and reason: |
| Do you have any concerns about your child's development? If yes, please describe: |

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| **Allergies** |
| Please list any allergies to medications or foods |
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| **Medications** |
| Please list any medications that your child takes including over the counter medications, herbs, vitamins and supplements. Include dose and frequency |
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| **Specialty Providers** |
| In order that we can best coordinate your child's care, please list any medical providers the child sees outside of this practice and list the year that they last saw them |
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| **Health Literacy Questionnaire** |
| Many times in healthcare staff and providers use words that are unfamiliar to the general population. Please rate the following questions on a scale of 1 to 10; 1 being strongly disagree and 10 being strongly agree |
| I feel that I have a thorough understanding of the instructions that my doctors and nurses give me about my child’s health |  1 2 3 4 5 6 7 8 9 10 |
| I feel that I remember the instructions given to me at my child’s doctor’s office when I get home |  1 2 3 4 5 6 7 8 9 10 |
| I feel that I have a strong understanding of medical language |  1 2 3 4 5 6 7 8 9 10 |

Parent Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_