Prestige Medical Group

PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.		**Date:**
Name *(Last, First, M.I.):*	☐ **M** ☐ **F**	DOB:

Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY		
Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*
List any medical problems that other doctors have diagnosed		
Surgeries		
Year	Reason	Hospital
Other hospitalizations		
Year	Reason	Hospital
Fractures, Ligament, & Tendon injuries		
Year	Injury	Doctor/Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother			**Grandmother** *Maternal*		
Siblings	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

SOCIAL HEALTH

What school do you attend?		
What grade are you in?		
What is your parent's marital status?		
What is your living arrangement? (Who do you currently live with?)		
How many siblings do you have?		
Are you exposed to tobacco smoke? If yes, by who?	☐ Yes	☐ No

GIRLS ONLY

Age at onset of menstruation: Date of last menstruation:		
My periods are every ________ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _______ Number of live births _______		
Are you currently pregnant or breastfeeding?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Date of last pap exam?		

BOYS ONLY

Do you feel any pain or burning with urination?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Do you perform regular self testicular exams?	☐ Yes	☐ No
Date of last testicular exam?	☐ Yes	☐ No

Signature:____ Date:_______________________