Pediatric & Adolescent Care

Health questionnaire for newborns

Dear Parent:

By filling out this questionnaire, you give us a more complete record of your child. Answer any question you can. Don't worry about those you skip. We will discuss with you any items that either you or we believe should be explained more fully.

Full name of child: ____

Family History: Have any close relatives had problems with the following? Relationship to this child (maternal/paternal parent, grandparent, sibling, etc.)

Deafness ______________________________

Asthma ______________________________

Tuberculosis ______________________________

Heart disease (prior to age 50) ______________________________

High blood pressure (prior to age 50) ______________________________

High cholesterol ______________________________

Anemia/bleeding disorders ______________________________

Liver disease ______________________________

Kidney disease ______________________________

Diabetes (prior to age 50) ______________________________

Bed-wetting (after 10- years of age) ______________________________

Epilepsy, convulsions/neurological ______________________________

Immune problems, immune deficiency

(childhood cancer, HIV, AIDS, etc.) ______________________________

Thyroid problems ______________________________

Are there smokers in the Home? Yes ________ No ________

Mother's name: ____________________________________ DOB: ______________

Father's name: ____________________________________ DOB: ______________

List ages, sex and general health of this child's brothers & sisters:

Name: ______________________________ Age _____ Sex _____ Health ok ______ Not ok ______

Illnesses: ____

Name: ______________________________ Age _____ Sex _____ Health ok ______ Not ok ______

Illnesses: ____

Name: ______________________________ Age _____ Sex _____ Health ok ______ Not ok ______

Illnesses: ____