# WellOne Primary Medical and Dental Care
# PEDIATRIC HEALTH QUESTIONNAIRE (0-18)

**DATE OF BIRTH ___/___/___ CHILD'S NAME_____ SEX ❑ M ❑ F**

**PREGNANCY & BIRTH** ***(Complete this section if it is your first visit to the health center)***

Birth Weight _____lbs ___oz ❑Single or ❑Multiple birth
Was the birth ❑Premature ____weeks ❑On time ❑Late?
Was the delivery ❑Vaginal ❑C-Section ❑Forceps?
Did the Mother take fertility drugs? **Y N**
Did the Mother smoke during pregnancy? **Y N**
Did the Mother drink alcohol while pregnant? **Y N**
Did the Mother take any medications while pregnant? **Y N**
List_____
Did the Mother take any other drugs while pregnant? **Y N**
List_____

**Please check problems encountered by the Mother during pregnancy:**
❑Abroptio placenta ❑Placenta Previa
❑Bleeding ❑Premature labor
❑Diabetes
❑Swelling/Edema
❑High Blood Pressure ❑Toxemia
❑Kidney Infection ❑Vaginal Infection
❑Other (explain)_____
**The baby was** ❑Breast ❑Bottle ❑Both fed
**Does the baby have any congenital problems or deformities?** ❑No ❑Yes_____

**Please check all problems the baby had during the first month:** ❑Blue lips ❑breathing difficulties ❑Colic ❑Constipation ❑Diarrhea ❑Excessive spitting up ❑Infections ❑Jaundice/yellow ❑Poor sucking reflex ❑Seizures ❑Turned blue ❑Vomiting ❑Other_____

**DEVELOPMENT** ***(Complete this section if your child is under 3 years. List the month the child completed these)***

Smiled_____ Crawled _____ Walked alone _____ Teeth eruption _____
Sat alone _____ Fed himself _____ Transferred objects from one hand to the other _____
Turned to a voice _____ Said 2 words_____ Said 10 words_____

**FAMILY HISTORY** ***(Complete this section for <u>all</u> children)***

Mother's Name _____Age _____Living with child? ❑ Yes ❑No
Is the Mother in good health?❑ Yes ❑No(explain)_____
Father's Name _____Age _____Living with child? ❑ Yes ❑No
Is the Father in good health?❑ Yes ❑No(explain)_____
Does the child have Brothers and Sisters?❑ Yes Number :_____ ❑No Living with child? ❑ Yes ❑No

| NAME | AGE | HEALTH PROBLEMS |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**FAMILY HISTORY** ***(Place a check mark next to all illnesses and conditions which the grandparents, parents, brothers and sisters have/had. Complete for <u>all</u> children.)***

❑Alcohol Abuse ❑Bleeding Disorders ❑Epilepsy ❑Kidney Disease ❑Thyroid Disease
❑Anemia ❑Cancer ❑Heart Disease/Attacks ❑Mental Illness ❑Other (list)
❑ Asthma ❑Depression ❑Hepatitis ❑Sickle Cell Anemia ❑ _____
❑Birth Defects ❑Diabetes ❑Hey Fever ❑Stroke/CVA ❑ _____
❑Blood Clots ❑Drug abuse ❑High Blood Pressure ❑Tuberculosis ❑ _____

**The LAST PHYSICAL EXAM WAS ON_____.IT WAS CONDUCTED BY_____.**

**The LAST DENTAL EXAM WAS ON _____. It was conducted by _____.**

**THE CHILD'S MEDICAL HISTORY** ***(Check all illnesses and problems the child has had. Complete for all children)***

❑Alcohol Abuse ❑Congenial Heart Disease ❑Hay Fever ❑Mouth (❑Blisters ❑Sores ❑Lumps)
❑Anemia ❑Constipation ❑Headaches-freq ❑Mumps ❑Sore throats -frequent
❑Arthritis ❑Depression ❑Hearing loss ❑Orthodontic care ❑Speech problems
❑Asthma ❑Diabetes ❑Hepatitis ❑Orthopedic problems ❑Swelling ankles/feet
❑Bed wetting ❑Drug problems ❑High Cholesterol ❑Periodontal disease ❑Tonsillitis
❑Bleeding Disorders ❑Ear infections-frequent ❑Hives ❑Pneumonia ❑Tuberculosis
❑Bowel Problems ❑Ear - ringing ❑HIV Positive ❑Rashes ❑Ulcers
❑Bronchitis/Croup ❑Eczema ❑Injury jaw/mouth ❑Rectal Pain/Bleeding ❑Urine infections
❑Bruises easily ❑Emotional distress ❑Jaundice ❑Rheumatic Fever ❑Vaginal Pain/Bleeding
❑Chicken Pox ❑Eye Disorders ❑Jaw clicking/popping ❑Scarlet Fever ❑Other _____
❑Contact lenses ❑Fainting ❑Meningitis ❑Sleeping problems
❑ Concussion ❑Fractures ❑Mental illness ❑Short of Breath

**SURGERY, INJURIES, PROCEDURES &HOSPITALIZATIONS** ***(Check all surgeries and injuries the child has had. Complete for all children)***

❑Appendix ❑Blood transfusions ❑Ear tubes❑Hernia ❑Teeth extraction❑ Tonsils/Adenoids ❑Other (_____)

**INJURIES** ***(List type and Date)***_____

_____

**HOSPITALIZATIONS & PROCEDURES*(Enter reason and date)*** _____

**ALLERGIES**

***(Complete for all children)***

❑ The child has No Known Allergies ***(skip to IMMUNIZATIONS)***

The child is allergic to the following **MEDICATIONS**: ❑Amoxicillin ❑Aspirin ❑Cefaclor ❑Codeine
❑Erythromycin ❑Iodine ❑Local anaesthetics ❑Narcotics ❑ Penicillin ❑Sedatives/sleeping pills
❑Sulfa (Bactrim, Septra) ❑Other _____

The Reaction to the drugs include_____

The Child is allergic to these **Foods** (list) _____

The Reaction to the foods include_____

The child is allergic to **Insect bites** from ❑Bees ❑Wasps ❑Spiders ❑Other_____

The Reaction to the drugs include_____

The Child has **environmental** allergies to ❑Cats ❑Dogs ❑Dust ❑Pollen

The Reaction to the drugs include_____

**IMMUNIZATIONS**

The child has been given immunizations from a past Physician or clinic ❑Yes ❑No. If yes, I give my permission for WellOne to receive the children past medical records from:

**(Name &Address)** _____

for the purpose of providing the child health care. This includes information regarding HIV testing, alcohol and drug treatment. The child was treated by said physician from _____ to _____.

Signature _____Date _____

**SAFETY** ***(Please answer for all children)***

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Does anyone smoke in the home? | ❑ | ❑ | Do you have a smoke detector in the home? | ❑ | ❑ |
| Do You have any guns in the home? | ❑ | ❑ | Is your hot water heater turned down to 120_? | ❑ | ❑ |
| Do you use sun screen #15 or higher? | ❑ | ❑ | Do you know CPR/Heimlich maneuver? | ❑ | ❑ |
| Does the child wear a bike helmet? | ❑ | ❑ | Do you live in a home built before 1978? | ❑ | ❑ |
| Do you have syrup of ipecac in the | ❑ | ❑ | Do you have chipping paint in your home or one he/she visits? | ❑ | ❑ |

**PERSONAL & SCHOOL (Please check if any of the following which are troubling the child or family)**

❑The child is having difficulty paying attention in school.

❑The child is having difficulty playing with other children.
❑The child has been absent from school more than 10 days.
❑The family is having financial worries.
❑The family is having difficulty with housing/rent/heat.
❑A family member, living in the home, (other than the child) is having emotional difficulties.
❑The child does not have a regular bed time.
❑The child has frequent temper tantrums.
❑The child hits, bites, kicks routinely when frustrated or angry.
❑The child does not follow the instructions of parents and teachers.
❑The child will take things that do not belong to him/her.
❑Date of first menses _____
Do you engage in activities which could cause injury to your teeth? ❑Yes ❑No explain: _____
Do you wear a mouth guard ❑Yes ❑No
The child watches_____ hours of TV per day.

| **NUTRITION** | | **YES** | **NO** |
|---|---|---|---|
| Does the child have any eating difficulties? | ❑ | ❑ | |
| Does the child eat meat, fruits, vegetables, breads, cereals and dairy products daily? | | ❑ | ❑ |
| Are sweets and "junk" food limited? | | ❑ | ❑ |
| Does the child eat 3 meals a day? | | ❑ | ❑ |
| Does the child eat or chew on window sills? | | ❑ | ❑ |
| Does the child or family receive WIC services? | | ❑ | ❑ |

**MEDICATIONS**

❑The child does not take any prescription medications, over the counter medications or herbal supplements regularly**.**
❑The child takes the following medications(both prescription & over the counter) and herbal supplements regularly:

**MEDICATION AMOUNT FREQUENCY**

_____

Other medications taken in the past 6 months are:_____
_____

**SIGNATURE_____DATE: ____/_____/_____**
**RELATIONSHIP TO CHILD** ❑Parent ❑Grand parent ❑ Foster Parent ❑Legal guardian ❑Other
**PROVIDERS SIGNATURE: _____DATE REVIEWED _____/_____/_____**