

**PATIENT QUESTIONNAIRE – BOCA PEDIATRIC GROUP**

Welcome to our practice! Please fill in this form as *completely as possible* to help us learn more about your child.  
If questions are not applicable, please indicate N/A.

Name of patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Reason for today's visit : \_\_\_\_\_

**PAST HISTORY: (PREGNANCY, LABOR, BIRTH AND FIRST WEEK OF LIFE)**

- 1) Was there an unusual illness or complications of pregnancy? [Y] [N] If yes, explain: \_\_\_\_\_
- 2) Name of the doctor that delivered your baby: \_\_\_\_\_ Type of delivery? C-section or Vaginal  
Name of hospital: \_\_\_\_\_
- 3) Birth weight? \_\_\_\_\_ lbs \_\_\_\_\_ oz. Length? \_\_\_\_\_
- 4) Any problems with baby at birth? Breathing [Y] [N] Jaundice [Y] [N] Other: \_\_\_\_\_  
How long was the baby in the nursery? \_\_\_\_\_

**PAST MEDICAL HISTORY:**

- 1) Has your child experienced an unusual number of illnesses or other health problems requiring medical care?  
[Y] or [N] If yes, please explain: \_\_\_\_\_
- 2) Does your child have an allergy to any medication? [Y] or [N] If yes, please list: \_\_\_\_\_
- 3) Does your child suffer from allergies of any kind? [Y] or [N] Please list: \_\_\_\_\_
- 4) Does your child take medications on a regular basis? [Y] or [N] Please list: \_\_\_\_\_
- 5) Has your child ever been hospitalized? [Y] or [N] When? \_\_\_\_\_ Reason: \_\_\_\_\_
- 6) Has your child ever had surgery? [Y] or [N] When? \_\_\_\_\_ Reason: \_\_\_\_\_
- 7) Please indicate if your child has ever had any of the following:  
 Colic  Feeding problems  Ear infections  Frequent colds  Wheezing  Asthma  Hepatitis  
 Seizure/convulsions  Skin rash  Eczema/hives  Urinary infections  Strep throat  Anemia  
 Medication reactions  Joint problems  Foot or leg problems  Behavior problems  OTHER \_\_\_\_\_  
Comments: \_\_\_\_\_

**DEVELOPMENT AND BEHAVIOR:**

- 1) As far as you know, is your child's development normal? [Y] or [N] Comments: \_\_\_\_\_
- 2) At what age did your child: Sit alone? \_\_\_\_\_ Walked? \_\_\_\_\_ Used sentences? \_\_\_\_\_ Toilet trained? \_\_\_\_\_
- 3) Grade in school? \_\_\_\_\_ Any problems in school? [Y] or [N] Please explain: \_\_\_\_\_
- 4) Any behavior problems? [Y] or [N] Please explain \_\_\_\_\_
- 5) Any use of street or illegal drugs? [Y] or [N]

**FAMILY PROFILE/HISTORY:**

- 1) Father's age: \_\_\_\_\_ In good health? [Y] or [N] Mother's age: \_\_\_\_\_ In good health? [Y] or [N]
- 2) Are parents  Married  Not Married  Divorced  Separated  
Number of other children in the family: \_\_\_\_\_ Please list brothers/sisters & their ages below:  
\_\_\_\_\_  
\_\_\_\_\_
- 3) Do any family members/blood relatives of your child have or have had any of the following (if Yes, please indicate family member): \_\_\_\_\_  
 Diabetes  Asthma  Anemia  Epilepsy/Seizures  Mental retardation  Drug or Alcohol problem  
 Cancer  AIDS  Cystic Fibrosis  Tuberculosis  Heart disease  High blood pressure  Migraine  
 Nervous breakdown  Birth defects  Early deafness  Sudden Infant Death  Hay fever  
 Other or comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What arrangements for child care are available in your absence? \_\_\_\_\_  
Name and relationship of the person completing this form? \_\_\_\_\_  
Today's date: \_\_\_\_\_

**Thank you!**