MOUNT NITTANY PHYSICIAN GROUP

# Pediatric Patient Questionnaire



**Patient Name: _____ Date of Birth: _____**

**Pharmacy**
Retail: _____
Mail Order:_____

**Preferred Method of Reminder Communication**
I would like to receive reminder communication via:
☐Patient portal ☐Cell phone ☐Home phone
☐Mail ☐Work phone

**Other than needing glasses or contacts, does the parent/guardian have any visual impairment affecting reading?** ☐Yes☐No
**Does the parent/guardian have any vision/hearing impairment?** ☐ YES☐ NO
**Explain: _____**

**HEALTH CARE TEAM:** Please list other health care providers that your child may see (example: Cardiologist)

| Name | Specialty |
|---|---|
| | |
| | |
| | |

**Child's birth weight (if under 1 year old) _____lb. _____oz**

**ACTIVE PROBLEMS/PAST MEDICAL HISTORY**
Does your child currently have any of the following medical problems? Place "X" in **ACTIVE** Problem column.
Has your child had any of the following medical problems in the past? Place "X" in **PAST** Problem column.

| | Active Problem | Past Problem | | Active Problem | Past Problem | | Active Problem | Past Problem |
|---|---|---|---|---|---|---|---|---|
| **Acid Reflux** | ☐ | ☐ | **Depression** | ☐ | ☐ | **Hyperthyroidism** | ☐ | ☐ |
| **Anemia** | ☐ | ☐ | **Developmental Delay** | ☐ | ☐ | **Hypothyroidism** | ☐ | ☐ |
| **Anxiety** | ☐ | ☐ | **Diabetes** | ☐ | ☐ | **Learning disability** | ☐ | ☐ |
| **Arthritis** | ☐ | ☐ | **Digestive Problem** | ☐ | ☐ | **Neuromuscular Disorder** | ☐ | ☐ |
| **Asthma** | ☐ | ☐ | **Eating Disorder** | ☐ | ☐ | **Overweight** | ☐ | ☐ |
| **Autism Spectrum** | ☐ | ☐ | **Genetic Disorder** | ☐ | NA | **Prematurity** Weeks gestation_____ | ☐ | ☐ |
| **Bleeding Disorder** | ☐ | ☐ | **Head Injury** | ☐ | ☐ | **Seizure** | ☐ | ☐ |
| **Breech Birth** | NA | ☐ | **Headaches** | ☐ | ☐ | **Skin disorder** | ☐ | ☐ |
| **Cancer _____** | ☐ | ☐ | **Hearing Difficulty** | ☐ | ☐ | **Tuberculosis** | ☐ | ☐ |
| **Childhood Behavior Problems** | ☐ | ☐ | **Hospitalized** (1+ nights other than routine normal newborn stay) | NA | ☐ | **Urinary Tract Infection** | ☐ | ☐ |
| **Congenital Heart Defect** | ☐ | ☐ | **History of ear infections** | ☐ | ☐ | **Vision Problem** | ☐ | ☐ |
| **Cystic Fibrosis** | ☐ | NA | **Hyperlipidemia** (High cholesterol) | ☐ | ☐ | | | |
| **Dental Cavities** | ☐ | ☐ | **Hypertension** (High Blood Pressure) | ☐ | ☐ | | | |

Has your child had any other serious medical problems not listed previously? ☐ YES ☐ NO
If YES, please list: _____

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**Patient Name: _____Date of Birth**: _____

PAST SURGICAL HISTORY

☐ *No history of prior surgery

Has your child had any of the following surgical procedures, ***include year if known:***

Adenoids removed ☐ Yes ☐ No Year_____ Elective Circumcision ☐ Yes ☐ No Year_____

Appendix removed ☐ Yes ☐ No Year_____ Hernia repair ☐ Yes ☐ No Year_____

Ear Tubes Inserted ☐ Yes ☐ No Year_____ Tonsils removed ☐ Yes ☐ No Year_____

List any other ***operations or surgeries*** your child has ever had, ***including year if known***:

| Type of Surgery | Year |
|---|---|
| | |
| | |
| | |

**FAMILY HISTORY**

Is there any of the following in your child's immediate family? Check all that apply

☐ Patient is Adopted

| | Mother | Father | Brother | Sister | Other: |
|---|---|---|---|---|---|
| Family History Unknown | ☐ | ☐ | ☐ | ☐ | ☐ |
| Alcohol Abuse | ☐ | ☐ | ☐ | ☐ | ☐ |
| Anxiety | ☐ | ☐ | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bipolar Disorder | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | | | | | |
| • _____ | ☐ | ☐ | ☐ | ☐ | ☐ |
| • _____ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ |
| Drug Abuse | ☐ | ☐ | ☐ | ☐ | ☐ |
| Celiac Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Allergies | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ | ☐ |
| High Cholesterol | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hip Dysplasia | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lung Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Seizures | ☐ | ☐ | ☐ | ☐ | ☐ |
| Died from heart disease before age 50 | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sudden Infant Death Syndrome | NA | NA | ☐ | ☐ | ☐ |
| Other: | ☐ | ☐ | ☐ | ☐ | ☐ |

**Patient Name: _____Date of Birth**: _____

**Immunizations: We require a copy of your child's immunization record.**

**SOCIAL HISTORY**

**For children under age 5, who primarily watches your child during the day? Check all that apply**:

☐Parent/Guardian ☐Daycare Center/Home Daycare ☐ Grandparent or other relative ☐ Babysitter

☐Other: _____

**Dental Care**

*Does your child have a dental checkup at least yearly? ☐YES ☐NO

**Living Situation: Select which best describes your child's living situation. Check all that apply.**

| | |
|---|---|
| ☐ Lives in group home<br>☐ Lives with father (single parent)<br>☐ Lives with foster parents<br>☐ Lives with friend<br>☐ Lives with grandparent(s)<br>☐ Lives with mother (single parent) | ☐ Lives with parents in same household<br>☐ Lives with parents who live in different households<br>☐ Lives with relatives<br>☐ Other: _____ |

**Does anyone that lives in the home smoke either inside or outside the home?** ☐Yes ☐No

**ALLERGIES**

Does your child have any allergies? ☐YES ☐NO

If YES, please list:

| Name | Type of Reaction |
|---|---|
| | |
| | |
| | |

Please List all MEDICATIONS your child is presently taking. Please include prescriptions, over the counter, vitamins, herbal and/or other supplements:

| **Name of Medication** | **Strength (Ex 50 mg)** | **Directions (Ex. 1 pill twice daily)** | **Why do you take this medication?** | **Who prescribed this medication?** |
|---|---|---|---|---|
| **ONLY COMPLETE THIS SECTION IF YOUR CHILD IS A NEW PATIENT** | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Patient/Representative Signature _____ Date: _____

Person who completed form if patient unable_____

**Patient Name: _____ Date of Birth: _____**

## PLEASE HAVE THE PATIENT WHO IS 13 AND OLDER COMPLETE THIS PAGE

**Smoking History (Check one):**

☐ Current smoker How many cigarettes per day? _____
☐ Former smoker When did you quit? _____
☐ Never a smoker
☐ Other _____

**Smokeless Tobacco History (Check one):**

☐ Never used smokeless tobacco
☐ Former user of smokeless tobacco When did you quit? _____
☐ Smokeless tobacco use What type of smokeless tobacco? _____

**Alcohol Usage (check one):**

☐ Alcohol Use
☐ No Alcohol Use

**Illicit Drug Use–(check one):**

☐ Current drug use
☐ History of drug use
☐ No drug use What types of drugs? _____

Patient/Representative Signature _____ Date: _____

Person who completed form if patient unable_____