Name: _____

Birthdate: _____

Children's MINNESOTA | Partners in Pediatrics

F14a-092

REFERRED TO PARTNERS IN PEDIATRICS BY: _____

YOUR CHILD'S SOCIAL HISTORY

FAMILY MEMBERS & THOSE LIVING IN YOUR HOME? *(List person completing form first)*	RELATIONSHIP TO CHILD	BIRTHDATE	OCCUPATION

Please list previous medical clinics at which your child has been treated: _____

Please list schools or daycare your child has attended: _____

YOUR CHILD'S BIRTH HISTORY — **GIVE DETAILS BELOW**

Were there any complications during the pregnancy? ..... N Y
Did the mother smoke? ..... N Y
Did the mother take drugs or prescribed medications? ..... N Y
Were there any complications during the labor or delivery ..... N Y
Were there any problems after the birth? ..... N Y

What was your child's gestational age? _____

What was your child's birthweight?
_____ lb _____ oz

YOUR CHILD'S HEALTH

Has your child ever been hospitalized? ..... N Y
Has your child ever had surgery? ..... N Y
Has your child had any chronic or serious illnesses? ..... N Y
Has your child ever had any major injuries? ..... N Y
Has your child missed any of his/her immunizations (shots) ..... N Y
Is your child on any medication currently? ..... N Y
Has your child had any reaction or allergy to any medication? ..... N Y
Does your child use any alternative or complimentary medicine (chiropractic, homeopathic, supplements, etc.) .... N Y

YOUR CHILD'S NUTRITION

Did/Does your child have any feeding or eating difficulties? ..... N Y
Has your child ever been put on a special diet? ..... N Y
Do you have any concerns about your child's weight or diet? ..... N Y
Does your child only drink well water, bottled or filtered water? ..... N Y
If so, has the fluoride content been checked? ..... Y N

YOUR CHILD'S DEVELOPMENT — **GIVE DETAILS BELOW**

Does/did your child have any problems or delays in development? ..... N Y
Has your child ever had any difficulty with:
Reading? ..... N Y
Spelling? ..... N Y
Mathematics? ..... N Y
Speech? ..... N Y
Writing? ..... N Y
Coordination? ..... N Y
Does your child receive any special services at school ? ..... N Y
Does/did your child have any behavioral or disciplinary problems? ..... N Y

Please list below any other questions or concerns that you would like to have addressed today:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PARENT SIGNATURE: _____

DATE | NEW PATIENT QUESTIONNAIRE | PROVIDER SIGNATURE

MEDICAL HISTORY