

PEDIATRIC GEMS, PC
EDMOND SARRAF, MD
450 N. BEDFORD DR. STE 209
BEVERLY HILLS, CA 90210
1-310-888-7778
www.pediatricgems.com

INITIAL HEALTH QUESTIONNAIRE AGES 1 TO 5

(please print)

Name of Patient: _____ D.O.B. _____ M ___ F ___

Medications: include all prescription, nonprescription, maintenance & as needed meds

Name _____ Dose _____ How often ? _____

Name _____ Dose _____ How often ? _____

Allergies: please specify type, reaction (hives, swelling, etc.), severity (mild, moderate or severe) & interventions (benadryl, epi pen, etc.)

• To Medications - _____ • To Food - _____

• Insects, Animals, Other - _____

Immunizations: Up-to-date? Yes ___ No ___ PLEASE BRING OR FAX RECORDS.

Birth History:

Born where _____ Birth Weight _____ Length _____ Type of Delivery _____

_____ Gestational Age _____ Hep B given at birth? Yes _____ No _____

Breast or Bottle? _____

Mother's Pregnancy Health:

Abnormal Labs/Tests? _____ Birth Complications _____

Problems during the hospital course _____

Past Medical History:

What type of medical

problems: _____

History of Hospitalizations: No ___ Yes ___ *If yes, please give details.*

Date _____ Location _____ Reason _____

History of Surgeries: No ___ Yes ___ *If yes, please give details.*

Date _____ Location _____ Procedure Performed _____

Family Medical History indicate who in relationship to child has the following problems...

Unremarkable (Please select this if all answers below are no) _____

Gastrointestinal Problems _____	High Cholesterol _____
Anemia _____	Skin Conditions _____
Nasal Allergies _____	Liver Disease _____
Asthma _____	Kidney Disease _____
Bronchitis _____	Bedwetting >10yrs old _____
Wheezing _____	Epilepsy, Seizures or Convulsions _____
Mental Illness _____	Autism _____
Heart Disease <50yrs old _____	Alcohol Abuse _____
Heart Attack <50yrs old _____	Diabetes <50yrs old _____
Blood Pressure <50yrs old _____	Genetic Disorders _____
Migraines _____	Other Immune Problems _____
Cancer; list type _____	

Social History:

General:

Parent Information: Married ___ Separated ___ Divorced ___ Single Parent ___

Primary Caretaker: Mother ___ Father ___ Other _____

Pets: Yes__ No__; If so, what type & how many? _____

Guns in the household: Yes__ No__; If yes, are the guns locked & separate from ammunition?

Infants & Children <6yrs old:

Childcare: Home with parents _____ Home with Babysitter _____ Babysitter in private home _____

Family Daycare _____ Childproofing appropriate for age: Yes _____ No _____

Development:

Reached milestones at a normal age: Yes___ No___ Not sure ___

Delayed? Yes___ No___; If yes, what area? _____

Is your child receiving therapy? No__ Yes___

If yes, what type? Speech__ Occupational Therapy__ Physical Therapy__ Other _____

If yes, where? _____