

PEDIATRIC GEMS, PC
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INITIAL HEALTH QUESTIONNAIRE AGES 6 TO 12
(please print)

Name of Patient: _____ D.O.B. _____ M ___ F ___
Form Completed by: _____ Relationship to Patient: _____ Date Completed: _____

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:

Abnormal Labs/Tests? _____ Any Birth Complications? _____
Any 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?

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? _____