

**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? \_\_\_\_\_