Cary Healthcare Associates, P.A.

Pediatric Health Questionnaire Form

Patients Name: _____ Date: _____

Date of birth: _____

Your Current Health

Please list any current medical conditions and medications taken on a regular basis

Illness/Condition	Medications	Dose/Frequency

Drug Allergies: _____

Other Allergies: _____

Medical History

Please list any hospitalizations or surgeries and dates if known:

_____

Were there any significant complications during pregnancy or delivery for the child?

_____

Any recurrent illness, behavioral problems, or any problems/concerns we should be aware of and discuss?

_____

Family History:

Family Member	Name	DOB	Health Problems
Father			
Mother			
Sibling(s)			

Social History:

Does your child attend daycare or school? Yes No Is your child home schooled? Yes No

Does anyone in your home smoke? Yes No Do you have pets? Yes No What kind?

Do you have city water or well water? Yes No _____

Are you worried about your child's safety at home? Yes No

* Please bring child's current immunization record.