Shakti Matta MD, MS, FAAP
Pediatrics *for* You, PLLC
6802 W Rio Grande Ave. Suite 1, Kennewick, WA 99336
PH: 509-572-2201 FAX: 509-783-8844
www.pediatricsforyou.com

Health History Questionnaire

Childs Name ______________________ Parents Name ______________________

DOB ______________________ Date ______________________

BIRTH HISTORY (for children up to 5 yrs and younger)

Mode of Delivery ☐ Vaginal ☐ C-section
Gestation: Premature ☐ No ☐ Yes ______________ weeks
Complications ☐ No ☐ Yes ______________
Birth Weight ______________
Hearing Screen ☐ Pass ☐ Fail
Newborn Screen ☐ Normal ☐ Abnormal
Hepatitis B vaccine given at birth? ☐ No ☐ Yes

ALLERGIES

Medication ☐ None ☐ Yes ______________
Other ☐ None ☐ Yes ______________

MEDICATIONS ☐ None ☐ Yes ______________
Please list name, dose and frequency: ______________

PAST MEDICAL HISTORY

Allergies ☐ No ☐ Yes ______________
Asthma ☐ No ☐ Yes ______________
ADD/ADHD ☐ No ☐ Yes ______________
Bed Wetting ☐ No ☐ Yes ______________
Cerebral Palsy ☐ No ☐ Yes ______________
Developmental Delay ☐ No ☐ Yes ______________
Diabetes ☐ No ☐ Yes ______________
Eczema ☐ No ☐ Yes ______________
Ear Infection ☐ No ☐ Yes ______________
Reflux ☐ No ☐ Yes ______________
Hearing Difficultly ☐ No ☐ Yes ______________
Heart Disease ☐ No ☐ Yes ______________
Hydrocephalus ☐ No ☐ Yes ______________
Lazy Eye ☐ No ☐ Yes ______________
Pneumonia ☐ No ☐ Yes ______________
Prematurity ☐ No ☐ Yes ______________
RSV Infection ☐ No ☐ Yes ______________
Seizure ☐ No ☐ Yes ______________

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Spina Bifida ☐No ☐Yes____________________
Thyroid Disease ☐No ☐Yes____________________
Urinary Tract Infection ☐No ☐Yes____________________
Vision Difficulty ☐No ☐Yes____________________
Others ☐No ☐Yes____________________

PAST SURGICAL HISTORY

Circumcision ☐No ☐Yes____________________
Tonsillectomy ☐No ☐Yes____________________
Adenoidectomy ☐No ☐Yes____________________
Ear tubes ☐No ☐Yes____________________
Please List ____
____

FAMILY HISTORY – Please limit to siblings, parents and grandparents

Allergies ☐No ☐Yes____________________
Alcohol/Drug Abuse ☐No ☐Yes____________________
Asthma ☐No ☐Yes____________________
ADD/ADHD ☐No ☐Yes____________________
Bleeding Disorder ☐No ☐Yes____________________
Cancer ☐No ☐Yes____________________
Diabetes ☐No ☐Yes____________________
Depression ☐No ☐Yes____________________
Hearing Loss ☐No ☐Yes____________________
Heart Disease(>50 yrs) ☐No ☐Yes____________________
Hypertension ☐No ☐Yes____________________
High Cholesterol ☐No ☐Yes____________________
Immune Deficiency ☐No ☐Yes____________________
Seizure Disorder ☐No ☐Yes____________________
Spina Bifida ☐No ☐Yes____________________
Thyroid Disease ☐No ☐Yes____________________
Others ☐No ☐Yes____________________

SOCIAL HISTORY

Parents Marital Status________________ Number of Siblings____________________
Attends Daycare/School ☐No ☐Yes, Grade________
Tobacco Smoke Exposure ☐No ☐Yes
Does your child have any special Needs? ☐No ☐Yes____________________

THANK YOU! This questionnaire is used for collection of information to help enter the information in electronic medical records.