Stony Brook Medicine

Pediatric Outpatient History Questionnaire

Reason for referral: _____

Birth History:

Birth weight: _____ Full term: □ Yes □ No

Premature: Gestational Age: _____ weeks

Vaginal delivery: □ Yes □ No Complications: □ C-section

□ Breech □ Failure to progress

□ Fetal Distress □ Other: _____

Mother's age at delivery: _____ Baby's birth order: □ 1st □ 2nd □ 3rd □ 4th □ 5th □ 6th

Regular newborn nursery: □ Yes □ No Neonatal intensive care unit: □ Yes, how long: _____ □ No

Discharge from hospital with mother: □ Yes □ No

Development History:

Did child ***walk*** by age 14 months: □ Yes □ No

Did child ***speak short phrases*** by age 24 months: □ Yes □ No

At what age (months) did the child ***speak first word***: _____ ***short phrases***: _____

roll over: _____ ***crawl***: _____ ***sit***: _____ ***walk***: _____ ***ride tricycle***: _____

Has your child had any delayed milestones: _____

Child enrolled in an Infant (Early Intervention) Program: □ Yes □ No

Why/What were the problems: _____

Education History:

Present grade: _____ Attend preschool: □ Yes □ No

Therapeutic (special education): □ Yes □ No

Name of School: _____

Is child in regular class: □ Yes □ No

Special Education: □ Yes □ No

Resource Room: (□ reading □ math □ all) □ Yes □ No

Has child ever failed a grade: □ Yes □ No

Social History:

Place of birth: _____ Raised: _____

Does the child live with mother and father: □ Yes □ No If not, describe: _____

Mother's age: _____ Education: _____ Occupation: _____

Father's age: _____ Education: _____ Occupation: _____

Family History:

Is your child adopted? □ Yes □ No (if medical history of blood relatives known, describe below)

Father: □ Alive, Age: _____ □ Deceased, Cause of Death: _____

Mother: □ Alive, Age: _____ □ Deceased, Cause of Death: _____

Does the child have any siblings: □ Yes □ No How many: _____

Please list any illnesses in the following family members:

Father: _____

Mother: _____

Grandparents: _____

Brothers: _____

Sisters: _____

Children: _____

Other: _____

Stony Brook Medicine

Pediatric Outpatient History Questionnaire

Family History (cont'd):

Does anyone in the family have neurologic problems: □ Yes □ No if Yes, describe: _____
Does anyone in the family have psychiatric problems: □ Yes □ No if Yes, describe: _____
Does anyone in the family have problems similar to your child's problem: □ Yes □ No if Yes, describe: _____

_____

Past Medical History:

Has your child ever been ***hospitalized***: □ Yes □ No if Yes, describe: _____

Immunization History:

Are your child's immunizations up to date: □ Yes □ No

Has your child ever had the following?

Strep throat: □ Yes □ No if Yes, describe: _____
Asthma: □ Yes □ No if Yes, describe: _____
Heart problems: □ Yes □ No if Yes, describe: _____
Lung problems: □ Yes □ No if Yes, describe: _____
Kidney problems: □ Yes □ No if Yes, describe: _____
Stomach problems: □ Yes □ No if Yes, describe: _____
Colon problems: □ Yes □ No if Yes, describe: _____
Depression: □ Yes □ No if Yes, describe: _____
Psychiatric illness: □ Yes □ No if Yes, describe: _____
Alcohol/drug abuse: □ Yes □ No if Yes, describe: _____
Poisoning (with what): □ Yes □ No if Yes, describe: _____
Endocrine disorder: □ Yes □ No if Yes, describe: _____
Infectious disease: □ Yes □ No if Yes, describe: _____
Lyme disease: □ Yes □ No if Yes, describe: _____
Other: □ Yes □ No if Yes, describe: _____
Attention Deficit Disorder: □ Yes □ No if Yes, describe: _____
Stroke/TIA: □ Yes □ No if Yes, describe: _____
Seizure: □ Yes □ No if Yes, describe: _____
Migraine: □ Yes □ No if Yes, describe: _____
Learning disability: □ Yes □ No if Yes, describe: _____

Does your child have allergies (including medications): □ Yes □ No
If yes, describe: _____ Medication Names: _____

What medication is your child taking now from a non-Stony Brook physician?

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____

Any medications recently stopped:

_____	_____	_____