UCLA Health System

MRN:
Patient Name:

(Patient Label)

UCLA DEPARTMENT OF FAMILY MEDICINE

PEDIATRIC QUESTIONNAIRE
Initial Health History

Date:

SOCIAL HISTORY

Place of birth:	Language spoken at home:
Name of Mother:	Occupation:
Name of Father:	Occupation:
Other/Guardian:	Occupation:

Who lives at home?

FAMILY HISTORY *(please list your immediate family members below)*

Name	Age	Relationship to patient	Health Problems

Are there any blood relatives who have had any of these problems?

☐ Asthma	☐ Birth Defects	☐ Cancer	☐ Diabetes
☐ Drug/alcohol	☐ High blood cholesterol	☐ High blood pressure	☐ Hyperactivity
☐ Mental retardation	☐ Psychiatric illness	☐ Seizures	☐ Sickle cell disease
☐ Tuberculosis			

BIRTH HISTORY

Name and location of hospital:

Problems during pregnancy:

Birth weight: Full term? ☐ Yes ☐ No Type of Delivery: ☐ Vaginal ☐ Cesarean Section

Problems during or immediately after birth:

Went home after: *(number of days)*

DEVELOPMENT

Please write at which age your child first began to:

Sit alone: Walk alone: Use single words: Toilet trained:

Any school problems now or in the past?

Name of present school: Grade level:

MEDICAL HISTORY

Current Medications:

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PEDIATRIC QUESTIONNAIRE
Initial Health History

MEDICAL HISTORY *(continued)*	
List any major illnesses, operations or hospitalizations below	Date(s)
1.	
2.	
3.	
4.	
ALLERGIES	
List any reactions your child has to foods, medications, or insects below	
Reviewed by: _____ Date reviewed: _____	