

Cinco Ranch Pediatrics: Patient Questionnaire

Patient's Name _____

Date of Birth _____

Birth History

1. Birth weight _____ Place of Birth _____
2. Birth: Vaginal or Cesarean (please circle)
3. Was your baby born within 2 weeks of the due date? No Yes
If no, explain _____
4. Did mother have any illnesses or problems during pregnancy? Yes No
If yes, explain: _____
5. Did baby have any problems immediately after birth? Yes No
If yes, explain: _____

Medical History

1. Does your child have any serious medical conditions? Yes No
If yes, explain: _____
2. Has your child ever been hospitalized or had surgery? Yes No
If yes, explain _____
3. Does your child take any medications on a regular basis? Yes No
If yes, please list: _____
4. Is your child allergic to any medication or food? Yes No
If yes, please list: _____
5. Do you have any concerns about your child's development? Yes No
If yes, explain: _____

Family Medical History

Please list any major medical problems in the child's immediate family or grandparents:

Mother: _____

Father: _____

Siblings: _____

Paternal Grandparents: _____

Maternal Grandparents: _____

Completed by _____ Relationship: _____

Date _____