

# Benacare Medical Center, Inc.

## PEDIATRIC HISTORY & PHYSICAL QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  M  F

**Has anyone in the family ever had any serious illnesses or abnormalities?** (e.g., heart disease, diabetes, tuberculosis, etc.)

Yes  No If yes, please explain: \_\_\_\_\_

**Were there any problems with the pregnancy of this child?**  Yes  No If yes, please explain: \_\_\_\_\_

**Has this child ever had the following illnesses?** (check if yes, and provide date):

	Yes	Date		Yes	Date		Yes	Date
Diphtheria	<input type="checkbox"/>	_____	Ear/Nose/Throat Problems	<input type="checkbox"/>	_____	Joint Problems	<input type="checkbox"/>	_____
Whooping Cough	<input type="checkbox"/>	_____	Urinary/Kidney Problems	<input type="checkbox"/>	_____	Eye Problems	<input type="checkbox"/>	_____
Polio	<input type="checkbox"/>	_____	Muscle/Bone Problems	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	_____
Measles	<input type="checkbox"/>	_____	Anemia/Blood Problems	<input type="checkbox"/>	_____	Pneumonia	<input type="checkbox"/>	_____
Mumps	<input type="checkbox"/>	_____	Convulsions/Seizures	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	_____
Chicken Pox	<input type="checkbox"/>	_____	Intestinal Problems	<input type="checkbox"/>	_____	Nervous Problems	<input type="checkbox"/>	_____
Scarlet Fever	<input type="checkbox"/>	_____	Asthma	<input type="checkbox"/>	_____	Epilepsy	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	_____	Hay Fever	<input type="checkbox"/>	_____	Typhoid	<input type="checkbox"/>	_____

**Has this child ever had any of the following?** (check if yes, provide date and explain):

	Yes	Date	Explanation
Hospitalizations:	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	_____	_____
Surgeries:	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	_____	_____
Serious Injuries:	<input type="checkbox"/>	_____	_____
	<input type="checkbox"/>	_____	_____

**Has this child ever had serious health problems?**  Yes  No If yes, please explain: \_\_\_\_\_

**Is this child taking any medications at this time?**  Yes  No If yes, please explain: \_\_\_\_\_

**Does this child have any allergies?** (e.g. to medicines such as Penicillin, foods, grasses/pollens, etc.)

Yes  No If yes, please explain: \_\_\_\_\_

**Has this child had a Tuberculosis Skin Test?**

Yes  No If yes, give DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ RESULT: \_\_\_\_\_

**Give month and year for each immunization this child has received:**

Diphtheria, Tetanus, Pertussis (DTaP)	1 _____	2 _____	3 _____	4 _____	5 _____
Polio (IPV)	1 _____	2 _____	3 _____	4 _____	5 _____
Haemophilus (Hib)	1 _____	2 _____	3 _____	4 _____	
Pneumococcal (Prennar)	1 _____	2 _____	3 _____	4 _____	
Hepatitis B	1 _____	2 _____	3 _____		
Rotavirus	1 _____	2 _____	3 _____		
Human Papilloma Virus (Gardasil)	1 _____	2 _____	3 _____		
Measles, Mumps, Rubella (MMR)	1 _____	2 _____			
Hepatitis A	1 _____	2 _____			
Varicella (Chicken Pox)	1 _____	2 _____			
Influenza	1 _____				
Meningococcal	1 _____				
Tetanus, Diphtheria, Pertussis (Tdap)	1 _____				