Today's Date: ________________

Patient Label For Office Use Only

Sycuan Medical Dental Center
Tel: (619) 445-0707
Website: https://www.sycuanmedicaldentalcenter.org

PEDIATRIC HEALTH QUESTIONNAIRE

Thank you for choosing Sycuan Medical Dental Center as your healthcare provider. Please take the time to answer the following questionnaire for your child so we may better serve his/her healthcare needs.

PATIENT NAME: ________________________________ **DOB:** __________________

FAMILY HISTORY

Have any of your child's parents, grandparents, aunts, brothers, or sisters had any of the following conditions?				
Anemia	□ Yes	□ No	□ Not sure	Who:
Allergies	□ Yes	□ No	□ Not sure	Who:
Bed-wetting	□ Yes	□ No	□ Not sure	Who:
Childhood hearing loss	□ Yes	□ No	□ Not sure	Who:
Depression/Anxiety	□ Yes	□ No	□ Not sure	Who:
Diabetes	□ Yes	□ No	□ Not sure	Who:
Heart disease	□ Yes	□ No	□ Not sure	Who:
High cholesterol	□ Yes	□ No	□ Not sure	Who:
Kidney disease	□ Yes	□ No	□ Not sure	Who:
Mental health conditions	□ Yes	□ No	□ Not sure	Who:
Seizures/Epilepsy	□ Yes	□ No	□ Not sure	Who:
Substance abuse	□ Yes	□ No	□ Not sure	Who:
Thyroid/Endocrine disease	□ Yes	□ No	□ Not sure	Who:
Tuberculosis	□ Yes	□ No	□ Not sure	Who:
Asthma	□ Yes	□ No	□ Not sure	Who:
Alcohol abuse	□ Yes	□ No	□ Not sure	Who:
Cancer (before age 55)	□ Yes	□ No	□ Not sure	Who:
High blood pressure	□ Yes	□ No	□ Not sure	Who:

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Dental problems	□ Yes	□ No	□ Not sure	Who:
Learning developmental disability	□ Yes	□ No	□ Not sure	Who:
Heart attack	□ Yes	□ No	□ Not sure	Who:
Brain or nerve issues	□ Yes	□ No	□ Not sure	Who:
Sexually transmitted disease	□ Yes	□ No	□ Not sure	Who:
Liver disease	□ Yes	□ No	□ Not sure	Who:
Obesity	□ Yes	□ No	□ Not sure	Who:
Lung disease	□ Yes	□ No	□ Not sure	Who:
Bleeding disorder				
Arthritis				
Skin disorder/Rashes				
Eczema				

BIRTH HISTORY

Birth Weight: _______________

□ Full-term □ Preterm ______weeks □ Post-term ______weeks

Delivery: □ Vaginal □ Cesarean

Reason: ____

Any complications during birth or after birth? □ Yes □ No

Was the baby treated for jaundice? □ Yes □ No

If yes, please explain:____

Did the baby need to go to the NICU (neonatal intensive care unit)? □ Yes □ No

If yes, please explain:____

Were the initial feedings with □ Breast □ Bottle

If still breastfeeding, is your baby taking vitamin D? □ Yes □ No

During the pregnancy, did the mother:

Take prenatal vitamins? □ Yes □ No

Smoke or use e-cigarettes? □ Yes □ No

Drink alcohol? □ Yes □ No

Use marijuana? □ Yes □ No

Use illicit drugs? □ Yes □ No

Take other medications? □ Yes □ No

If yes, please list: ____

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Blood Type: Mother: ____________ □ Unknown Baby: ____________ □ Unknown
Mother's lab results: ___________________________
Hepatitis B: □ Positive □ Negative □ Unknown
HIV: □ Positive □ Negative □ Unknown
Group B streptococcus (GBS) □ Positive □ Negative □ Unknown

After birth, did the baby receive the following?
Vitamin K shot? □ Yes □ No □ Unknown
Erythromycin eye ointment? □ Yes □ No □ Unknown
Hepatitis B shot? □ Yes □ No □ Unknown
How was the baby fed? □ Bottle Formula □ Bottle breastmilk □ Breastfed
How long was the baby breastfed? _____________________________
Did the baby go home with the biological mother from the hospital after birth?
□ Yes □ No

Please Explain:
____
____
____

SOCIAL HISTORY

Please list other siblings not living at home:

NAME	RELATIONSHIP TO CHILD	BIRTH DATE	AGE
1.			
2.			
3.			
4.			
5.			

Does the child live with both biological parents? □ Yes □ No
If not, what is the child's current living situation?
□ Single-parent Custody
□ Joint custody
□ Adoptive family
□ Foster Care
□ Other family members: ____________________________________
How often does the child have visitation with parent(s) not living in the home?
____

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Please list all those living in the child's home:			
NAME	RELATIONSHIP TO CHILD	BIRTH DATE	AGE
1.			
2.			
3.			
4.			
5.			

MENTAL HEALTH		
1. Is there a family history of Mental Health Issues? If yes, please describe:	□ Yes	□ No
2. Do you think this child feels depressed?	□ Yes	□ No
3. Does this child have problems with eating or with their appetite?	□ Yes	□ No
4. Does this child have trouble sleeping?	□ Yes	□ No
5. Has this child received counseling?	□ Yes	□ No

SURGICAL HISTORY

Has your child ever had surgery? □ Yes □ No
If yes, please provide details below.

Surgery/Procedure	Date	Child's Age	Where Completed	Details
1.				
2.				
3.				
4.				
5.				

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HOSPITALIZATION-OVERNIGHT

Has your child ever been hospitalized? □ Yes □ No
If yes, please provide details below.

Reason	Date	Child's Age	Details
1.			
2.			
3.			
4.			
5.			

Has this child had any of the following problems?

□ ADHD
□ Alcohol or drug use
□ Allergies (seasonal)
□ Allergies (food)
□ Allergies (medication) if so, please specify
____
□ Anemia
□ Anxiety/Depression
□ Asthma
□ Bed Wetting
□ Behavior patterns
□ Blood Disorders (such as Sickle Cell Disease
□ Cancer
□ Constipation
□ Development Delays
□ Diabetes --- Insulin Dependent
□ Diabetes --- Not on Insulin
□ Ear Infections (frequent)
□ GERD/reflux
□ Genetic/metabolic problems
□ Heart Problems
□ History of abuse or family violence
□ Kidney Disease
□ Learning problems
□ Liver Disease
□ Menstrual Cycle problems
□ Age of first menstrual cycle if applicable ______________
□ Seizures
□ Skin problems (eczema, frequent abscesses, MRSA)
□ Sleep problems such as snoring or apnea
□ Tobacco use
□ Thyroid Disorder
□ Urinary Tract Infections
□ Feeding problems
□ Hearing problems
□ Vision problems
□ Pneumonia/lung problems
□ Meningitis
□ Serious injuries
□ Birth defects
□ Head traumas/concussion

Any other problems not listed:
____
____
____

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Please list the child's prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.		
Name of Drug	Strength	Frequency Taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

OTHER

Please list other medical problems:
____
____
____

Submitted by: ______________________________ Date: _____________________
Relationship to Child: _________________________________