

Pediatric History/Parent Questionnaire

Prenatal History:

Birth Weight _____ Height _____ Duration of Pregnancy _____

Type of Delivery: _____

Complications at birth:

Treatment Received by baby and/or mother:

Please list any injuries, illnesses, infections, hospitalizations, surgeries or other medical procedures your child has had and the ages these occurred:

Does the child have any allergies, seizures or other medical problems?

Current Medications:

Developmental Milestones: at what age did your child do the following?

Roll back to stomach _____

Roll stomach to back _____

Sit unsupported _____

Sit supported _____

Pull to stand _____

Crawl _____

Cruise _____

Walk _____

Climb stairs _____

Run _____

Begin eating solid foods _____

Finger feed self _____

Use utensils _____

Drink from cup _____

Living Arrangement (where, with whom, siblings, pets)

How does your child spend their day? (Preschool, school, daycare, etc.)

Please describe your concerns for this child?

What does your child like/dislike?

Is there anything else you would like us to know about your child?
