LSFP
PEDIATRIC HEALTH QUESTIONNAIRE

Name:	/ /	Date / /
Nickname:		BIRTHDATE

ALLERGIES (list reactions to **medicines**) ☐ none
1)
2)
3)
4)
5)

MEDICINES (ones taken regularly) ☐ none
1)
2)
3)
4)
5)
6)

SURGERIES (procedure and date) ☐ none
1)
2)
3)
4)

HOSPITALIZATIONS (reason and date) ☐ none
1)
2)
3)

MAJOR ACCIDENTS (occurrence and date) ☐ none
1)
2)
3)

Birthplace
Which school attended now?
Grade?
What year was your home built? (lead exposure?)

Tobacco exposure at home?	☐ no	☐ yes
Is seat belt or car seat always used	☐ yes	☐ no
Is helmet always used when bike riding?	☐ yes	☐ no
Is sunscreen regularly used?	☐ yes	☐ no
Is there a gun in your home?	☐ yes	☐ no
If so, is it locked away safely?	☐ yes	☐ no

List members of household and relationship to your child:
1)
2)
3)
4)
5)
6)
7)

Are immunizations up to date? ☐ yes ☐ no

Check any that your child has had or now has

☐ Allergies/Hayfever	☐ Headaches (severe)
☐ Anemia	☐ Headaches (frequent)
☐ Arthritis	☐ Hearing problems
☐ Asthma	☐ Heart murmur
☐ Bed wetting (prolonged)	☐ High blood pressure
☐ Behavior probs (severe)	☐ Kidney disease
☐ Bladder infections	☐ Learning disability
☐ Bleeding problems	☐ Liver disease
☐ Bone disease	☐ Meningitis
☐ Bowel/colon disease	☐ Pneumonia
☐ Cancer	☐ Seizures
☐ Concussion	☐ Sickle cell disease
☐ Depression / ADD	☐ Skin problems (severe/recurrent)
☐ Ear infections (frequent)	☐ Sleep difficulties
☐ Diabetes	☐ Vision problems
☐ Other	

Pregnancy complication? ☐ no ☐ yes (explain yes below)
Birth complications? ☐ no ☐ yes

Check any that a close blood relative has had (and whom?)
☐ Alcohol problems
☐ Allergies
☐ Asthma
☐ Bleeding disorder
☐ Cancer
☐ Depression / ADD
☐ Diabetes
☐ Headaches (frequent/severe)
☐ Heart disease
☐ High blood pressure
☐ High cholesterol
☐ Kidney disease
☐ Migraines
☐ Obesity
☐ Sickle cell disease
☐ Thyroid disease
☐ Other

Any additional info you'd like us to know?