

**ANACORTES FAMILY MEDICINE/THE WALK-IN CLINIC AT ISLAND HOSPITAL  
NEW PATIENT PEDIATRIC MEDICAL HISTORY QUESTIONNAIRE**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**PARENTS - PLEASE HELP US BY ANSWERING THE FOLLOWING QUESTIONS ABOUT YOUR CHILD'S HISTORY**

	YES	NO	COMMENTS
Problems during pregnancy?			
Child born at full term?			If late or early - how many weeks?
Normal, vaginal delivery?			
Problems after delivery?			His/her birth weight:
Any smokers in the house?			
Has your child: Been Hospitalized? (please describe)			Breast fed?
Had any major injury/illness? (please describe)			Does either parent smoke?
Taken long-term medications? (please describe)			
Had any allergic reactions? (please describe)			To what?
Is he/she up to date with immunizations?			
His/her last complete check-up date:			Previous primary physician:
Concerns about his/her development:			
Medications:			

FAMILY HISTORY:	LIVING			DECEASED		HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD ONE OR MORE OF THE FOLLOWING?				
	Age	Health Good Fair Poor			Age at Death	Major Illnesses		YES	NO	Specify who
Father										
His Father										
His Mother										
Mother										
Her Mother										
Her Father										
Brother(s)										
Sister(s)										

Please list things you would like to discuss with your child's provider today and any information you feel is important


PLEASE SIGN:

\_\_\_\_\_  
Parent and/or guardian

Date: \_\_\_\_\_