Milepost Medical
Pediatric Medical Questionnaire (Birth - 5 years old)

Name:____ Date:_______________

Reason for today's visit:

Pregnancy/Birth history
Illnesses or medications during pregnancy?
Smoking Alcohol Drugs – during pregnancy?
At birth, how many gestational weeks was your child (full term = 40 weeks)?
Type of delivery? Vaginal C-section Birth weight: Birth length:
Single pregnancy Multiple (twin/triplet/etc) Complications?
Did baby receive the Hepatitis B vaccine in the hospital? Yes No Not sure

Past Medical History: Please mark if your child has had any of the following:

Vision Problems		Headaches		Learning Disability	
Hearing Problems		Seizures		Developmental Delay	
Ear Infections		Cancer		ADHD/ADD	
Sinus Infections		Diabetes		Bleeding Tendency	
Allergies		Reflux		Blood Transfusion	
Asthma		Jaundice		Anemia	
Pneumonia		Urinary Problems		Eczema	
Heart Problems		Joint Problems		Skin Infections	
Heart Murmur		Thyroid Problems		Sleep Problems	
Other:					

Surgical History: Please mark if your child has had any of these surgeries (what YEAR)

Appendix Removal	
Adenoid Removal	
Tonsil Removal	
Ear Tubes	
Bone Surgery	
Circumcision	
Other:	

Immunizations up to date? Yes No Unsure Please provide vaccine record.
Hospitalizations or Serious Injuries or ER Visits (Please list):

MEDICATIONS: Please list all prescription or over-the-counter medications your child is taking.

Medication	Dosage	Frequency	Reason for Taking	Need refill today?
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

Allergies to Medication/Food/Other: PLEASE DESCRIBE THE REACTION (rash, nausea, etc)

Development
How does your child compare to other children his/her age? Advanced Same Behind
At what age did you child… sit alone? Walk? Talk?
At what age was your child potty trained?

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Feeding and Nutrition
Currently: Breastfeeding Formula Table food Milk____oz/day(Whole, 2%, 1%, Skim) If breastfeeding or formula, how much? How often? Formula type:
Does your child receive vitamins? Yes No

Is your child CURRENTLY having any of the following symptoms?					
Fever		Shortness of Breath		Vaginal Discharge	
Weight Loss		Cough		Diaper Rash	
Weight Gain		Wheezing		Rash	
Swollen Glands		Trouble Breathing		Itching	
Vision Problems		Turning Blue		Allergies	
Eye Drainage		Vomiting		Limb Pain	
Ear Drainage		Diarrhea		Headaches	
Hearing Problems		Constipation		Seizures	
Nosebleeds		Abdominal Pain		Snoring	
Runny Nose		Loss of Appetite		Sleeping Difficulty	
Nasal Congestion		Pain with Urination		Behavior Problems	
Sore Throat		Blood in Urine		Easy Bruising	
Speech Problems		Scrotal Swelling		Easy Bleeding	

Social History
Members of Household:
Childcare: Home with Parent Nanny Other Family Daycare □Other
Does your child participate in any extracurricular activities? (Please list)
At home are there: Smokers Pets Swimming Pool Guns Smoke Detectors

Family History: Please check if your child's family members have any of the following:
(MGM=mother's mother, MGF=mother's father, PGM=father's mother, PGF=father's father)

	Mother	Father	MGM	MGF	PGM	PGF	Sibling	Cousin
Allergies								
Anemia								
Arthritis								
Asthma								
Birth Defects								
Cancer								
Diabetes								
Heart Disease								
High blood Pressure								
High Cholesterol								
Mental Retardation								
Migraines								
Psychiatric Illness								
Seizures								
Sudden Infant Death								
Thyroid Problems								
Tuberculosis								
Other								

Family history unknown / child is adopted

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Child's Name:____ Date of Birth:_________________

Mother's Name: ________________________________ Age:_____ Occupation: _______________

Father's Name: ________________________________ Age:_____ Occupation: _______________

Address: ____

City: ________________________ State: _______ Zip: ______________

Phone: Home: ____________________Cell: ____________________Cell: ____________________

Email Address: ____ Child's Gender: M / F

Insurance Information:
Why do we ask for this? While we do not bill your insurance for our services, it is important that we know what your insurance coverage is to help make sure we refer you to services that are within your network. If you do not have insurance, just leave this section blank.

Insurance Company: ____

Policy Number: __________________________________ Group Number: ______________________

Pharmacy Info:

Local Pharmacy Name: ____________________________ Phone Number: ______________________

Location: ____

Mail Order Pharmacy Name: ____

Confidential Communication (Please check one):

I give permission for Milepost Medical to release my child's medical information (or leave a message) to the following person(s):

Name: _________________________Phone #: _____________________Relationship: ___________

Name: _________________________Phone #: _____________________Relationship: ___________

I do not give permission for Milepost Medical to release information to anyone other than to the child's parents.

In case of emergency, please let us know whom we may contact:

Name: _________________________Phone #: _____________________Relationship: ___________

Name: _________________________Phone #: _____________________Relationship: ___________

How did you hear about us?
Family/Friend Internet ☐Facebook ☐Flyer Other________________________
Physician Referral________________________