Milepost Medical
Pediatric Medical Questionnaire (>5 years old)

Name:_____ Date:_____

Reason for today's visit:

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
				☐ Yes ☐No

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

Development
Does your child have developmental problems?
How does your child compare to other children his/her age? ☐Advanced ☐Same ☐Behind
For Females: Age at first menstrual period_____ Last menstrual period_____

Feeding and Nutrition
How many servings of the following does your child eat per day? ____Meat ____Bread ___Dairy ___Fruits/Vegetables
How much milk does your child drink per day? ____ounces (☐Whole, ☐2%, ☐1%, ☐Skim)
Does your child receive vitamins? ☐Yes ☐No

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

Social History
Members of Household:
School Name and Grade:_____
Has your child repeated any grades? ☐Yes ☐No
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_____