Past Medical History (ROS) Questionnaire

Mount Dora Pediatrics

Patient's Name ____________________

DOB: ____________________

Today's date ____________________

Pregnancy and Birth History

Where was your baby born?
____

Were there any problems during the pregnancy?
☐ yes ☐ no

Was your baby born premature? (Less than 37 weeks)
☐ yes ☐ no

Did the baby have any problems just after birth?
(failed to breath, required resuscitation , unable to maintain color)
☐ yes ☐ no

Did your baby have any troubles while in the hospital?
(Required oxygen, IV or medicines, transferred to an intensive care)
☐ yes ☐ no

Feeding & Nutrition History

What infant formula do you (did you) use?
____

If breast fed, is the (was the) production NOT adequate?
☐ yes ☐ no

Does (did) your child have feeding problems in the first months?
☐ yes ☐ no

Do any types of food disagree with your child?
☐ yes ☐ no

If so what types of foods?
____

Is your child on a special diet?
☐ yes ☐ no

What type diet?
____

Is constipation a problem?
☐ yes ☐ no

Does your child take vitamins or supplements?
☐ yes ☐ no

If taking vitamins or supplements, what kind?
____

Child's Medical History

Does your child take medicines?
☐ yes ☐ no

List medicines____________________

Do they take any alternative medicines, therapies, or supplements?
☐ yes ☐ no

List ____________________

Has your child had any surgeries?
☐ yes ☐ no
List the surgeries____________________

Does your child have a chronic/recurrent medical problem?
☐yes ☐ no
List: ____________________

Has your child ever been hospitalized?
☐ yes ☐ no

Why was the child hospitalized?____________________
____

Has your child had poor growth? (Height and or Weight)
☐ yes ☐ no

Has your child struggled with obesity?
☐ yes ☐ no

Has your child had poor weight gain or weight loss?
☐ yes ☐ no

Does your child have a vision problem?
☐ yes ☐ no

Does your child have hearing problems?
☐ yes ☐ no

Has you child had more than 4 ear infections per year?
☐ yes ☐ no

Does your child have sleep difficulties?
☐ yes ☐ no

Does your child snore/snort with snoring?
☐ yes ☐ no

Has your child every had a seizure?
☐ yes ☐ no

If so, was the seizure associated with fever?
☐ yes ☐ no

Has your child ever been hospitalized or seen in the ER for a head injury?
☐ yes ☐ no

Has your child ever had a bladder or kidney infection?
☐ yes ☐ no

If greater than 6 years old does your child still bed wet?
☐ yes ☐ no

Has your child had any bone or joint injury, infection or fractures?
☐ yes ☐ no

Allergies

Is the child allergic to any foods or medicines?
☐ yes ☐ no

List the medicines or foods
____

Were there symptoms other than a rash to the food or medicine?
(i.e. Wheezing, shortness of breath, passing out, red eyes, mouth swelling, swallowing problems)
☐ yes ☐ no

List symptoms: ____________________

Has your child ever been treated for recurrent eczema ?
☐ yes ☐ no

Has your child ever been treated for wheezing or Asthma?
☐ yes ☐ no
(i.e. nebulizer, inhaler medicines)

Has your child been admitted to the hospital or intensive care for wheezing?
☐ yes ☐ no

Development

Do you have any concerns about delays in your child's speech, motor coordination or learning ?
☐ yes ☐ no

Has your child ever received therapy or testing for a developmental problem? (Speech, motor, or learning)
☐ yes ☐ no

If your child is in Pre-K or School, are they having learning difficulties?
☐ yes ☐ no

Does your child have any behaviors that concern you ?
☐ yes ☐ no

List the behavior(s)
____
____

Was your child able to sit alone at 6 to 7 months?
☐ yes ☐ no

Was your child walk alone at 12 to 15 month?
☐ yes ☐ no

Was your child able to walk up steps by 2 to 3 years?
☐ yes ☐ no

Was your child able to pedal a tricycle by 3 to 4 years?
☐ yes ☐ no

Was your child able to feed self with fingers by 12 months?
☐ yes ☐ no

Was your child able to feed self with spoon by 2 to 2 ½ years?
☐ yes ☐ no

Please Continued to the Back

Was your child able to cut with children's scissors by 3 to 3 ½?
☐ yes ☐ no
Was your child able to zip their zipper by 4 years?
☐ yes ☐ no
Did your child able to understand "yes/no" by 9 to 12 months?
☐ yes ☐ no
Was your child able to say Mama (to Mom) or Dada (to Dad) by 10 to 12 months?
☐ yes ☐ no
Was your child able to say 5 or 10 words by 18 months of age?
☐ yes ☐ no
Was your child putting 2 words together (noun + verb) at 2 years?
☐ yes ☐ no
Was your child able to use 20 to 50 words at 2 years
☐ yes ☐ no
Was a family friend able to understand at least 50% of your child's language at 2 to 2 ½ years
☐ yes ☐ no
Was your child able to use 3 words in a sentence by 3 years?
☐ yes ☐ no
Did your child show interest in playing with other children at 2 to 3 years of age? ☐ yes ☐ no

Immunizations
Are the child's immunizations behind?
☐ yes ☐ no
Has your child ever had a reaction to an immunization?
☐ yes ☐ no
List the symptoms of the reaction to the immunization
____
Has your child ever had a chickenpox rash?
☐ yes ☐ no
What was the date (if known) of the child's last tetanus?
____
Has your child ever had a positive skin test for TB
☐ yes ☐ no

Environment & Safety
Does any one in the household smoke?
☐ yes ☐ no
Does this person smoke inside the house or car?
☐ yes ☐ no
Does your child NOT (or refuse to) use safety belts or car seat?
☐ yes ☐ no
Are there any pets in the household?
☐ yes ☐ no
List the types of pets ______________________________
Is your house historic or in an historic district?
☐ yes ☐ no
When was your house built? (approximately)________________
Is your household on a well water system?
☐ yes ☐ no
Does anyone in the household work at home with Lead, Pesticides, Herbicides, Batteries, Flammable or hazardous materials?
☐ yes ☐ no
Are these hazardous materials in reach of the children?
☐ yes ☐ no
Is (are) there a gun(s) in the household?
☐ yes ☐ no
Is the gun NOT locked up or within reach of the children?
☐ yes ☐ no
Do you or the neighbors have a swimming pool ?
☐ yes ☐ no
If so, do any of these pools, NOT have a locked four sided fence?
☐ yes ☐ no
Does your child NOT wear a helmet when riding a Bike Motorcycle, or 4 wheeler? ☐ yes ☐ no
Does your child refuse to wear seatbelts or sit in car seat?
☐ yes ☐ no
Has your child ever been a victim or a witness of abuse?
☐ yes ☐no

Family History of the Child's Parents, Siblings and Cousins

How old is Mom? ___________Dad?_________________
What is the highest level of education obtained by
Mom ________________Dad_____________________
Does either parent have any health problems?
☐ yes ☐ no
What kind of health problems?
____
Do any of the child's siblings have any health problems?
☐yes ☐ no
What kind of health problems?
____
List the age and name(s) each of the brother(s) and or sister(s)
____
____
Has anyone in the family have history of high cholesterol?
☐ yes ☐ no
Does anyone in the family have high blood pressure ?
☐ yes ☐no
Has anyone had a heart attack under the age of 50 yrs?
☐ yes ☐ no
Has anyone died suddenly/unexpectedly from a heart disorder?
☐ yes ☐ no
Does anyone have Diabetes?
☐ yes ☐ no
Does anyone have Asthma?
☐ yes ☐ no
If so who? _________________________________
Does any Adult in the household have/had Tuberculosis ? (fever, night sweats, cough with blood, weight loss)
☐ yes ☐ no
Does anyone suffer from Lupus or Rheumatic joints?
☐ yes ☐ no
Does anyone have Hearing Loss that developed in childhood?
☐ yes ☐ no
Does anyone have Mental Retardation?
☐ yes ☐ no
Does anyone have a Learning disorders?
☐ yes ☐ no
Does anyone Autism or Aspergers Syndrome?
☐ yes ☐ no
Does anyone in the family suffer from depression/anxiety?
☐ yes ☐ no
Does anyone suffer from Bipolar disorder?
☐ yes ☐ no
Has anyone have/had recurrent seizures or epilepsy?
☐ yes ☐ no
Does anyone in the immediate family have a cancer?
☐ yes ☐ no
If so who & what type___________________________
Does anyone have a disorder of metabolism?
(An enzyme deficiency: PKU, Galactosemia, maple syrup etc)
☐ yes ☐ no
Does anyone have a disorder of immunity?
(Cannot fight infections or prone to frequent & unusual infections)
☐ yes ☐ no

Office use only
Reviewed by MD _________________________________
Date____