WHITE-WILSON
MEDICAL CENTER, P.A.

Supplemental Pediatric Questionnaire: **under 12 months**

Date:_____

Patient Name_____ Date of Birth_____

Nickname_____ Birth Weight_____ Birth Height_____

Address_____

Parents Name: Mother_____Father:_____

Who does the child reside with_____

Number of siblings and age_____

Phone Number:_____ and any alternate _____

Specify any problems at birth:_____ Any birth defects_____

During pregnancy, did you have any problems with :

Medications_____ (please list and give side effects known).

Please circle the following, if you had any known complications during pregnancy:

High blood pressure, Anemia, Diabetes, RH factor, Virus Infection, Bleeding, Infectious Disease

Who delivered your baby _____

Please identify your labor and delivery

Normal____ Breech_____ Difficult_____ C-section_____

If not normal please explain_____

Any serious illness_____

What formula is your baby taking _____ , and how many ounces in 24 hours_____oz.

Is your child eating or drinking other food items, if yes please list how much_____

Vaccine:

DPT_____,_____, Polio_____,_____

MMR _____HIB_____,_____TB Tine_____

Do you have any concerns or questions for the doctor today

_____

_____