IDEAL PEDIATRIC & ADOLESCENT CARE

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TEL: 570-551-0300

PATIENT HEALTH QUESTIONNAIRE

Date: _____

Patient Name: _____ D.O.B: _____

Patient Birth History:

Place of Birth: _____

Circle one: Full Term or Pre-Term Circle one: Vaginal or C-Section

Birth Complications: _____

Patient Past Medical History: _____

Patient Past Surgical History: _____

Patient Hospitalizations: _____

Patient Medications: _____

FAMILY HISTORY/Relationship to patient

Asthma: _____ Sudden Death: _____

Autism: _____ High Blood Pressure: _____

Heart Disease: _____ Seizure: _____

High Cholesterol: _____ Leukemia: _____

Allergies: _____ ADHD: _____

Cancers: _____ Anxiety: _____

Depression: _____ Eating Disorders: _____

Social History: Who lives in the home with the patient?_____

Circle one: Parents are: married divorced separated other

If parents not living together how is custody shared? N/A 50/50 Other:_____

Pets in home: _____

Smokers in family: Who smokes cigarettes or e cigarettes?

Concerns for substance abuse (drugs or alcohol)? _____

Signature: _____ Relationship to patient:_____