## Greater Roslindale Medical and Dental Center

## Pediatric Wellness Questionnaire

Our goal is to improve your child's overall health by discussing preventative care. Therefore, during his or her Annual Wellness Exam we will review your child's health information, such as his/her medical problems, past surgeries and the medical history of the family. Your child's medical team will develop a personal health care plan for your child.

Please answer these questions to the best of your ability:

Child Name: _____

Date of Birth: _____

Does your child have any new medical problems since their last Well Child Exam? Yes No

If "yes" please explain: _____

Do you feel that you understand your child's medical problem? Circle One: Yes No

Communication Needs: Please share with us if you child has any communication needs_____

Please review and circle Yes or No

Hearing Problems: Yes No

Vision Problems: Yes No

Trouble thinking or Understanding Yes No

If "yes" please explain: _____

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**Family History:**

Are there medical problems in your child's family? Yes No

Place an "X" in appropriate boxes to identify all illnesses/conditions in your family history

| Illness / Condition | Family Member | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Grandparent | Father | Mother | Brother | Sister | Son | Daughter | Other |
| Colon or Rectal Cancer | | | | | | | | |
| Other Cancer | | | | | | | | |
| Heart Disease | | | | | | | | |
| High Blood Pressure | | | | | | | | |
| Liver Disease | | | | | | | | |
| High Cholesterol | | | | | | | | |
| Alcohol/Drug Abuse | | | | | | | | |
| Depression Psychiatric illness | | | | | | | | |
| Genetic Disorder (inherited) | | | | | | | | |
| Other | | | | | | | | |

**Behaviors Affecting Health**

Does anyone in the household:

Smoke: Yes No

Use Alcohol: Yes No

History of or current drug use: Yes No

Social History:

Who does your child? _____

Who do you and your child consider your support system? _____

Is your child currently in daycare or school? Yes No

If yes, where? _____

What type of place to you live in: Circle One: House Apartment Other

Do you (parent) work? Yes No

Occupation? _____

Do you or your family have concerns about your child's health? Yes No

If "yes" explain _____

**Patient Medical History: Fill In Circle(s) That Apply**

| | | |
|---|---|---|
| ◯ Diabetes | ◯ Heart Murmur | ◯ Crohn's Disease |
| ◯ High Blood Pressure | ◯ Pneumonia | ◯ Colitis |
| ◯ High Cholesterol | ◯ Pulmonary Embolism | ◯ Anemia |
| ◯ Hypothyroidism | ◯ Asthma | ◯ Jaundice |
| ◯ Goiter | ◯ Emphysema | ◯ Hepatitis |
| ◯ Cancer (type) _____ | ◯ Stroke | ◯ Stomach or Peptic Ulcer |
| ◯ Leukemia | ◯ Epilepsy (seizures) | ◯ Rheumatic Fever |
| ◯ Psoriasis | ◯ Cataracts | ◯ Tuberculosis |
| ◯ Angina | ◯ Kidney Disease | ◯ HIV / AIDS |
| ◯ Heart Problems | ◯ Kidney Stones | |

◯ Other medical conditions please list: _____