PEDIATRIC GEMS, PC
EDMOND SARRAF, MD
955 S. Carrillo Dr Ste 210
Los Angeles CA 90048
1-310-888-7778
www.pediatricgems.com

INITIAL HEALTH QUESTIONNAIRE AGES 6 TO 12
(please print)

Name of Patient: _____ D.O.B. _____ M___ F ___
Form Completed by**:** _____Relationship to Patient: _____Date Completed: _____

Medications: include all prescription, nonprescription, maintenance & as needed meds
Name _____ Dose _____ How often ?_____
Name _____ Dose _____ How often ?_____

Allergies: please specify type, reaction (hives, swelling, etc.), severity (mild, moderate or severe) & interventions (benadryl, epi pen, etc.)
To Medications _____To Food _____Insects, Animals, Other _____

Immunizations: Up-to-date? Yes ___ No ___ PLEASE BRING OR FAX RECORDS.

Birth History:
Born where _____Birth Weight _____Length _____Type of Delivery _____
Hep B given at birth? Yes _____ No ____ Initial Feeding, breast or bottle? _____
Mother's Pregnancy Health:
Abnormal Labs/Tests?_____Birth Complications _____
Problems during the hospital course _____

Past Medical History:
What type of medical problems:_____

History of Hospitalizations: No ____ Yes _____ *If yes, please give details.*
Date _____ Location _____ Reason _____

History of Surgeries: No ____ Yes _____ *If yes, please give details.*
Date _____Location _____Procedure Performed _____

Family Medical History indicate who in relationship to child has the following problems…
Unremarkable (Please select this if all answers below are no) ____
Gastrointestinal Problems _____High Cholesterol _____Deafness _____Anemia _____Nasal Allergies _____
Liver Disease _____Asthma _____Kidney Disease _____Bronchitis _____Bedwetting >10yrs old _____
Wheezing _____Epilepsy, Seizures or Convulsions _____Tuberculosis _____Mental Illness or Retardation_____
Heart Disease <5oyrs old _____Heart Attack <5oyrs old _____Blood Pressure <50yrs old _____Alcohol Abuse _____
Drug Abuse _____HIV or Aids _____Migraines _____Other Immune Problems _____Diabetes <50yrs old _____
Skin Conditions _____Cancer; list type _____

Social History

General:
Parent Information: Married ___ Separated ___ Divorced ___ Single Parent ___

Patient lives with _____Home Occupants _____Primary Caretaker: Mother ___ Father ___ Other _____
Pets: Yes__ No__; If so, what type & how many? _____Smoking: Yes__ No__; If so where? _____
Alcohol Use: No ___ Yes ___Drug Use: No ___ Yes _____
Guns in the household: Yes__ No__; If yes, are the guns locked & separate from ammunition? _____

Infants & Children <6yrs old:
Childcare: Home with parents ____ Home with Babysitter ____ Babysitter in private home ____Family Daycare ____
Daycare Center (list name) _____
Childproofing appropriate for age: Yes ____ No ____ Need Information ____

Development:

Reached milestones at a normal age: Yes___ No___ Not sure ___
Delayed? Yes___ No___; If yes, in what area?_____
Has your child been evaluated? Yes___ No___; If so, by whom?_____
Is your child receiving therapy? No__ Yes___
If yes, what type? Speech__ Occupational Therapy__ Physical Therapy__ Other _____
If yes, where?_____