BALTIMORE CITY COMMUNITY COLLEGE
PEDIATRIC HEALTH QUESTIONNAIRE

DATE_____

CHILD_____ SEX: MALE FEMALE
LAST NAME FIRST NAME MIDDLE INITIAL

DATE OF BIRTH_____ PHONE NUMBER_____

PHYSICIAN'S NAME & ADDRESS _____

_____

Date of last complete physical examination_____

Please answer the following questions for your dependent.
Check one: "Y" = YES OR "N" = NO

1. Have you ever had abnormal bleeding following extractions of teeth or from a cut? ☐ Y ☐ N

2. Have you ever been treated for:

a. Behavioral disorders ☐ Y ☐ N
b. Heart problems ☐ Y ☐ N
c. Heart murmur ☐ Y ☐ N
d. Mitral valve prolapse ☐ Y ☐ N
c. Tuberculosis ☐ Y ☐ N
d. Kidney disorders ☐ Y ☐ N
e. Diabetes ☐ Y ☐ N
f. Skin disorders ☐ Y ☐ N
g. Rheumatic fever ☐ Y ☐ N
h. Mononucleosis ☐ Y ☐ N
i. Thyroid condition ☐ Y ☐ N
j. Hepatitis ☐ Y ☐ N
k. Arthritis ☐ Y ☐ N
l. Epilepsy/Seizures ☐ Y ☐ N
m. Asthma ☐ Y ☐ N
n. Anemia ☐ Y ☐ N
o. Other ☐ Y ☐ N

3. Do you have any allergies? ☐ Y ☐ N

4. Are you taking any form of medication presently? If yes, please describe. ☐ Y ☐ N

5. Are you sensitive to aspirin, penicillin, iodine, novocaine, or other medications? ☐Y ☐N

6. Have you ever been hospitalized? If so, why and when? ☐Y ☐N

7. Do you have spells of dissiness? ☐Y ☐N

8. Have you ever had bad nose bleeds? ☐Y ☐N

9. Do you suffer from stomach trouble? ☐Y ☐N

10. Has a doctor ever said you have kidney or bladder trouble? ☐Y ☐N

11. Have you ever been treated for ear problems? ☐Y ☐N

12. Have you ever been treated for eye problems? ☐Y ☐N

13. Has a doctor ever informed you that you have a tumor or cancer? ☐Y ☐N

14. Have you ever had severe pains of the face or head? ☐Y ☐N

15. Have you ever been diagnosed as having a learning disability? ☐Y ☐N

16. Have had the following immunizations:

a. tetanus ☐Y ☐N
b. rubeola (measles) ☐Y ☐N
c. mumps ☐Y ☐N
d. rubella (G measles) ☐Y ☐N
e. hepatitis ☐Y ☐N

DENTAL HISTORY

17. Please give the date of your last dental appointment and services performed. Also, give the name of the Dentist.

18. Are there any sensitive or sore areas in the child's mouth? ☐Y ☐N

19. Have you noticed any bleeding when your child brushes, while eating or at any other time? ☐Y ☐N

20. Please give the date of the child's most recent radiographs.

BW_____ FMS_____ PAN_____ Medical_____ Type_____

21.Give the frequency of brushing. Times per day? _____ Name of present toothpaste? _____

22.Emergency Contact: _____ Relationship: _____
23.Comments:

Parental Consent for Medical Treatment

Child's Information

_____ _____
Child's Name Date of Birth

_____ _____
Home Address Home Phone Number

_____
City, State, Zip Code

_____ _____
Parental Contact Phone Number

Caregivers Information

_____ _____
Caregiver's Name Phone Number

The above named caregiver shall be authorized to consent for all medical and/or surgical treatment and/or other medical procedures (including administration of anesthesia, blood transfusions, diagnostic test, etc.) for the above named child, which may be required during my absence. If circumstances permit, I would like to have our doctor consulted in connection with such treatment.

Please attempt to contact me at the following telephone number. _____

This consent serves as permission for treatment by _____ (Hospital Name). Note: Consents are not required in emergency situations. I agree to pay for all services provided to my child in my absence. This authorization shall be effective until: (select one)

a) _____ (Month, Day, Year) b) unless earlier revoked by me.

Signatures

_____ _____
Parent/Guardian (circle one) Date

_____ _____
Parent/Guardian (circle one) Date

_____ _____
Witness Date

Parental Consent for Medical Treatment

Family Physician Information

_____ _____
Name Phone Number

_____
Address

Insurance Information

_____ _____
Company Name Policy Number

Medical Information (Please print and be thorough)

Chronic or existing medical conditions
(E.G., Asthma, Seizures, Diabetes)

_____

_____

Known Allergies

Anesthetic ☐
Aspirin ☐
Codeine ☐
Demerol ☐
Antibiotics (Please List)

Insect Stings ☐
I.V.P. Dyes ☐
Morphine ☐
Novocain ☐

Penicillin ☐
Shellfish ☐
Tetanus Toxoid ☐

_____

Other (Please List)

_____

Current Daily Medications

_____

_____

Recent Shots and Vaccines

Tetanus/Date_____
Other/Date_____