

Dear Parent/Caretaker,

Thank you for choosing Pediatricadvice.net to assist with your healthcare needs. Please use the space below to write your question. Following your question you will find a health questionnaire which will be utilized to obtain specific, necessary information regarding your situation. Please fill out the questionnaire to the best of your knowledge. Some questions may require more than one answer and you may need to check more than one box. All information obtained will be held confidential and will not be shared with any other party. The information will be used solely for the purpose of understanding your situation more clearly and as a result you will receive advice that is specific to your particular situation. **Please remember not give your name or your child's name for confidentiality purposes.** Thank you.

Please fill out the following questions. Some questions may need more than one answer.

1. What is your child's age? _____years _____months
2. What is your child's sex? _____Male _____Female
3. What is your child's chief complaint or main symptom/problem? _____
4. How long ago did this problem start? _____
5. Is it: _____getting better _____getting worse _____staying the same
 _____got better but seems to be getting worse again
6. When does the problem occur? Put a check in all boxes that apply and put a **W** for time when it is the worst.
 _____morning _____afternoon _____evening _____Middle of the night _____before eating
 _____after eating _____during eating _____when child doesn't eat _____with exercise/movement
 _____when sitting _____when standing _____when lying down _____outdoors _____in rainy weather
 _____in cold weather _____in humid weather _____indoors _____when having a bowel movement
 _____when urinating _____when crying _____when talking _____when smelling odors/irritants
 _____at the babysitters/daycare _____at school _____in the automobile _____when the area is touched
 _____when bathing _____when diapering _____while taking medication _____when child is nervous
 _____when child is tired _____Other _____

7. Please best describe the problem?

constant intermittent(comes and goes) sporadic throughout the day

comes in cycles when exposed to something _____

only during waking hours only when the child is asleep

8. Are there any other symptoms or problems your child is having at this time?

irritability/crankiness inability to sleep not wanting to eat difficulty swallowing

not wanting to drink eating too much drinking a lot of fluids teething

chills cough wheezing difficulty breathing shortness of breath

breathing fast difficulty talking runny nose post nasal drip

stuffy nose sore throat stomach ache vomiting nausea

diarrhea constipation rash pain in chest halitosis(bad breath)

pain in front of neck pain in back of neck pain in legs recent weight loss

itching swelling or puffiness body aches joint pain

sleeping more than normal very tired headache change in personality

fever of degrees(How was temperature taken? rectal oral axillary

tactile) other, _____

no other symptoms

9. What did your child do the day before the problem began?

act normal had a fever didn't eat as much as normal was very cranky

was very tired had a runny nose was at the park did not sleep at home

at school on vacation played sports was at the zoo or by animals

at a restaurant tried new food tried new soap/lotion

played with another child who was sick at a party

other, _____

10. Was your child ill or sick within the last 4 weeks? No Yes

If yes explain (include date) _____

11. Is your child presently taking any of the following?

prescription medication over the counter medications

vitamins herbal remedies

If you answered yes to the previous question, please fill out the following chart.

Name of Medication	Dose	Form(liquid, chewable, pill)	Start Date	Stop Date	Times of day given	Side effects or Problems

12. Does anyone in the home have the same problem or illness? ___No ___Yes

13. Has your child had this same problem before? ___No ___Yes

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 If Yes, when?

 ___ within the past 2 weeks ___ within the past month

 ___ within the past 6 months ___ within the past year

 ___ more than one year ago

14. Does your child have any chronic medical conditions?

___ Asthma ___ Diabetes ___ Congenital Heart Disease ___ Immune deficiency

___ Gastrointestinal Reflux ___ Bleeding Disorder ___ Vesicoureteral Reflux

___ Cancer ___ Food allergies ___ Eczema ___ ADD/ADHD ___ Autism

___ Cerebral Palsy ___ Seizure Disorder ___ Migraines ___ Anorexia Nervosa

___ Scoliosis ___ Bulimia ___ Arthritis ___ Anemia ___ Celiac's Disease

___ Surgery, please explain _____

___ Hospital Admission, please explain _____

___ Other, _____

___ None

15. Please check all the following that apply to your child's birth.

- Low birth weight Premature, if so how many weeks early? weeks
- Large for gestational age admitted to the NICU needed resuscitation at birth
- treated for fever needed a respirator needed CPAP needed oxygen
- meconium stain had apnea went home on an apnea monitor
- born in another country born at home exposed to a communicable disease
- birth history not known passed hearing test received Hepatitis B Vaccine
- Vaginal Birth Breech presentation Cesarean section had problems sucking
- had feeding difficulties Jaundice treated with IV antibiotics
- other _____

16. Has your child been exposed to

- travel outside of the country someone who is incarcerated or in jail
- someone in a nursing home a visitor from another country who lives in the home
- a babysitter who travels outside of the country
- someone with a communicable disease, if yes, explain _____
- Other, _____
- None of the above

17. Is there any family history of the following? Please put a **P** for parent, **G** for grandparent, **S** for sibling, **C** for cousin, **A** for blood related aunt and **U** for blood related uncle. * Please note this only includes blood related family members.

- Asthma Recurrent Pneumonia Recurrent Bronchitis Cystic Fibrosis
- Sinus Problems Hayfever Anemia Bleeding Disorder Eczema
- Gastroesophageal Reflux Tuberculosis HIV Recurrent Urinary Tract/Kidney Infections
- Crohn's Disease Celiac's Disease Lactose Intolerance Irritable Bowel Syndrome
- Immune Deficiency Cancer Diabetes Seizure Disorder Depression
- Bipolar Disorder Schizophrenia Obsessive Compulsive Disorder Anxiety Disorder
- Eating Disorder Obesity Sudden Death of unknown cause Heart Arrhythmia
- Heart Attack under the age of 45 years old Passing Out during sports Short Stature
- Learning Disability ADD/ADHD Autism other _____
- the family history is not known

18. Are your child's immunizations up to date? Yes No I don't know

The Fee for a mail in Private Question is \$25.00.

Please mail the completed survey along with your check payable to:

Pediatric Advice
P.O. Box 6163
Parsippany, NJ 07054

*All checks must include preprinted address and your telephone number written on the check.

How would you like the answer to your question sent to you?

Please select ONE and enter the appropriate information:

Email _____

Or

US Postal Service

Name _____

Address _____

City _____ State _____ Zip _____

I have read the Pediatricadvice.net policies and understand that by submitting this health information that I give Pediatricadvice.net the right to review it for the purpose stated. I understand that it is my choice to include this health information with my submission. In accordance with the privacy policy I will not include my child's name or the name of practitioners or institutions caring for my child.

Please sign here X _____