PRE-VISIT PAEDIATRIC PATIENT QUESTIONNAIRE

Please complete this form and send it back prior to your child's appointment. All information provided will be treated in a strictly confidential manner and it will become a part of your child's medical record. It will help Dr Vaidya and other team members to provide you with the best health care possible.

DETAILS OF PATIENT	
Today's Date:	
Child's Full Name:	
Child's Date of Birth:	Age:
Main Concern:	
Any other concerns:	

MEDICAL HISTORY		
Does your child have any past medical history of a known condition?	☐Yes	☐No
If yes, please provide details:		
Are there any other Medical Specialists and/or Allied Health Therapists involved in the care of your child?	☐ Yes	☐ No
If yes, please provide details: 1. _____ 2. _____ 3. _____ 4. _____		

Has your child been hospitalised overnight?	☐ Yes	☐ No
If yes, please provide brief details:		
Does your child take any medications on a regular basis?	☐ Yes	☐ No
If yes, please provide Name, Dose, and any side effects:		

SURGICAL HISTORY		
Has your child had any of the following surgeries?		
Grommets	☐ Yes	☐ No
Tonsillectomy	☐ Yes	☐ No
Adenoidectomy	☐ Yes	☐ No
Appendix Removal	☐ Yes	☐ No
Any other surgery?		

FAMILY HISTORY				
Whom does the child live with in the same house?				
NAME	**RELATION**	**AGE**	**EDUCATION**	**OCCUPATION**

Is there a history of any of the following conditions in the child's **first relatives**? (I.e., Parents or siblings)		
Asthma	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Cardiac Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No

Mental Health Illness	☐ Yes	☐ No
ADHD	☐ Yes	☐ No
ASD	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Allergies or Anaphylaxis	☐ Yes	☐ No
Other	☐ Yes	☐ No
If yes to any of the above conditions, please provide brief details:		
Is there a history of any known genetic condition in the child's **extended family**?	☐ Yes	☐ No
If yes, please provide brief details:		

IMMUNISATIONS		
Is your child up to date with their immunisations?	☐ Yes	☐ No
ALLERGIES		
Does your child have any known Allergies? (Food/medication/other)	☐ Yes	☐ No
If yes, please provide details of reaction:		

PERSONAL DECLARATION
By signing below, you acknowledge that the information you have provided in this form is true and correct to the best of your knowledge. Name of person completing this form: _____ Relationship to the Child: _____ Signature: _____Date: _____