Riverdale Pediatrics, P.C.	Child's name:
	Date of birth:

Interval Medical History Questionnaire

Since the last exam:

Has your child had any illness or injury requiring a visit to the emergency room? If yes, list:	Yes ☐ No ☐ Don't know ☐
Has your child been to a specialist? If yes, list:	Yes ☐ No ☐ Don't know ☐
Has your child been hospitalized or had any surgery? If yes, list:	Yes ☐ No ☐ Don't know ☐
Has your child been to the dentist? If yes, to whom?	Yes ☐ No ☐ Don't know ☐
Has your child been to the ophthalmologist (eye doctor)? If yes, to whom?	Yes ☐ No ☐ Don't know ☐
Has your child received any immunizations elsewhere? If yes, list:	Yes ☐ No ☐ Don't know ☐
Have there been any changes in the family's medical history? If yes, list:	Yes ☐ No ☐ Don't know ☐

Medications and allergies:

Is your child taking any medications, vitamins or supplements? If yes, list:	Yes ☐ No ☐ Don't know ☐
Does your child have any allergies? If yes, list:	Yes ☐ No ☐ Don't know ☐

Your name	Your relationship to the child
Signature	Date

Riverdale Pediatrics, P.C.	Child's name:
	Date of birth:

Interval Social History Questionnaire

At home:

Any changes at home (have you moved, any renovation or construction, etc.)? If yes, describe:	Yes ☐ No ☐ Don't know ☐
Any changes in the family (new siblings, anyone moved in or moved out)? If yes, describe:	Yes ☐ No ☐ Don't know ☐
If separation or divorce, what are the custody, visitation and medical decision-making arrangements?	
Any smokers at home? Comments:	Yes ☐ No ☐ Don't know ☐
Regular use of seat belts/car seat? Helmets and protective sports equipment? Comments:	Yes ☐ No ☐ Don't know ☐

At school:

Where does your child go to school? Grade and/or special education?	
Does your child like school? Comments:	Yes ☐ No ☐ Don't know ☐
How is your child doing at school?	
Does your child have friends at school? Comments:	Yes ☐ No ☐ Don't know ☐
Do you or the teachers have concerns about his/her abilities and behavior? Comments:	Yes ☐ No ☐ Don't know ☐

Your name	Your relationship to the child
Signature	Date

Riverdale Pediatrics, P.C.	Child's name:
	Date of birth:

Additional Interval History Questionnaire

Nutrition:

Does the child eat a well-balanced diet? Comments:	Yes ☐ No ☐ Don't know ☐
Are there any food intolerances or allergies? If yes, describe:	Yes ☐ No ☐ Don't know ☐
Is the child a picky eater? Comments:	Yes ☐ No ☐ Don't know ☐

Routines:

Are there any sleep problems? Comments:	Yes ☐ No ☐ Don't know ☐
Are there any concerns regarding urinary or bowel routines? Comments:	Yes ☐ No ☐ Don't know ☐

Comments or concerns:

Your name	Your relationship to the child
Signature	Date