Paediatric Medical History Questionnaire

Please email the completed questionnaire to **benedikt@praxis-benedikt.de** no later than 24 hours before your appointment. We will be happy to discuss your responses with you during your consultation. All information is treated as strictly confidential and is subject to medical confidentiality.

Child and Parent / Legal Guardian Information

Child's Surname | First Name | Date of Birth | Gender

Parent(s) / Legal Guardian(s) Surname | First Name | Number and Age of Siblings

Postcode / City | Street / House Number

Telephone | Email | Paediatrician

1. Pregnancy and Birth

Number of pregnancies:

Were there any complications during pregnancy? ☐ No ☐ Yes — If yes, please specify

Were antibiotics taken during pregnancy? ☐ No ☐ Yes — If yes, which?

Was there a hospital admission during pregnancy? ☐ No ☐ Yes — Reason

Were there any other significant events, medical conditions or stresses during pregnancy
(e.g. gestational diabetes, hypertension, medication, surgery, severe nausea, stress, falls, separation, bereavement, fetal positioning):

Gestational age (weeks) | Birth weight (g) | Length (cm) | Head circumference (cm) | Place of birth

Total duration: | 1st stage (dilation): | 2nd stage (pushing):

Was labour induced? ☐ No ☐ Yes — Why / how?

1. Pregnancy and Birth - Continued

Was your child delivered by Caesarean section? ☐ No ☐ Yes Why?

Type of Caesarean Section: ☐ Planned ☐ Unplanned ☐ Emergency

Were any assisted delivery techniques used during birth? ☐ No ☐ Yes Which?

☐ Kristeller manoeuvre (fundal pressure) ☐ Forceps delivery

☐ Vacuum-assisted (ventouse) ☐ Other:

Were pain relief medications administered during birth? ☐ No ☐ Yes

If yes, which? (e.g. epidural, nitrous oxide, opiates/opioids, Meptid, or other)

Were there any complications during birth? ☐ No ☐ Yes If yes:

APGAR Score: 1 / 5 / 10 min

Umbilical Cord pH

Special medical interventions after birth

How did you experience the birth?

2. Child Information and Medical History

Reason for today's consultation / current concerns:

Your wishes for the treatment:

Is your child currently receiving medical treatment? ☐ No ☐ Yes Why?

Are there any medical reports available (e.g. X-rays, MRI, CT)? ☐ No ☐ Yes

Please bring any relevant reports or imaging results to your appointment.

Is your child currently taking any medication? ☐ No ☐ Yes Which?

Is your child in any other form of therapy? ☐ No ☐ Yes Which?

Type of therapy: ☐ Occupational ☐ Speech Therapy ☐ Physiotherapy ☐ Other

Accidents, injuries or operations (what happened and when):

Hospital admissions - Reason

Date / Duration

2. Child Information - Continued

Immunisations (Vaccinations)

Reactions following immunisations

Allergies / Skin Conditions (e.g. cradle cap, eczema/atopic dermatitis)

Pets

Are there any significant family or social circumstances affecting your child?

Infant feeding: ☐ Bottle-fed ☐ Breastfed

Duration of breastfeeding

Breastfeeding difficulties

Weaning - onset / tolerability

Excessive wind, reflux/spitting up, or vomiting - frequency and features:

Current weight (kg)

Other relevant information

Any serious or recurring medical conditions within the family? ☐ No ☐ Yes If yes:

3. Development and Milestones

Head control | Leopard crawling | Sitting | Crawling | Walking

Has gross motor development been unusual or delayed? ☐ No ☐ Yes If yes:

Any difficulties with fine motor skills? ☐ No ☐ Yes If yes:

Routine Child Health Examinations (U-Examinations) - abnormalities?

Social Development (smiling, babbling, interaction etc.)

4. Current Concerns

Does your child have any behavioural concerns?	☐ No	☐ Yes	If yes:	
Does your child have any concentration problems?	☐ No	☐ Yes	If yes:	
Difficulties in nursery, kindergarten or school?	☐ No	☐ Yes	If yes:	
Difficulties with toilet / potty training?	☐ No	☐ Yes	If yes:	
Does your child have sleep difficulties?	☐ No	☐ Yes	If yes:	
Squint (strabismus) or vision concerns?	☐ No	☐ Yes	If yes:	
Is your child's neck sensitive or painful?	☐ No	☐ Yes	Since when?	
Does your child have digestive problems?	☐ No	☐ Yes	If yes:	

Bowel movement frequency?

Concerns / symptoms related to bowel movements

5. Asymmetry

Hand dominance: ☐ Left ☐ Right ☐ Not yet established

Does your child appear physically asymmetrical or "crooked"?	☐ No	☐ Yes	Where?	
Does or did your child show a strong preference for one side?	☐ No	☐ Yes	Which?	
Did your child feed better from one breast than the other?	☐ No	☐ Yes	Which?	
Did or does your child dislike tummy time?	☐ No	☐ Yes	Since when?	
Does or did your child have a flattened head area?	☐ No	☐ Yes	Which side?	

Additional observations regarding posture, head shape or body symmetry:

6. Past Medical History

Does your child suffer from headaches?	☐ No	☐ Yes	Frequency?
Does your child experience frequent infections?	☐ No	☐ Yes	Type / how often?
Has your child had middle ear infections?	☐ No	☐ Yes	Last hearing test?
Does your child wear glasses?	☐ No	☐ Yes	Last eye exam?
Does or did your child wear braces?	☐ No	☐ Yes	Since when?
Does your child have allergies or intolerances?	☐ No	☐ Yes	If yes:
Does your child experience growing pains?	☐ No	☐ Yes	Where/when?
Other medical conditions or diagnoses?	☐ No	☐ Yes	If yes:

Any additional information important for your child's assessment or treatment:

Declaration

I confirm that the information provided is complete and accurate to the best of my knowledge. I understand that this questionnaire does not replace the personal medical history consultation.

Date

Name / Signature of Parent or Legal Guardian

Please note: please save the completed PDF using a new file name before returning it by email to benedikt@praxis-benedikt.de.