Today's Date:

# PEDS Medical and Feeding Questionnaire

**Please complete the questionnaire below to the best of your knowledge. Answer all questions that are relevant to you and your child.**

Child's Name: Date of Birth:

Parents'/Care Givers' Name(s):

## Child's Medical History:

**Please indicate whether your child or a family member have/had any of the following conditions:**

| Disease/Condition | Child | Family | Relationship | Treatment |
|---|---|---|---|---|
| Asthma | ☐ | ☐ | | |
| Cancer | ☐ | ☐ | | |
| Cardiovascular Disease | ☐ | ☐ | | |
| Diabetes | ☐ | ☐ | | |
| Eating Disorder | ☐ | ☐ | | |
| Food Allergies | ☐ | ☐ | | |
| Food Intolerances | ☐ | ☐ | | |
| Kidney Disease | ☐ | ☐ | | |
| Headaches | ☐ | ☐ | | |
| High Cholesterol | ☐ | ☐ | | |
| Hypertension | ☐ | ☐ | | |
| Intestinal Problems | ☐ | ☐ | | |
| Menstrual Problems | ☐ | ☐ | | |
| Mental Health Issues | ☐ | ☐ | | |
| Obesity | ☐ | ☐ | | |
| Osteoporosis | ☐ | ☐ | | |

Other

List any medications your child is presently taking or has taken in the last year:

Is your child currently taking any food supplements, vitamin, mineral, or herbal supplements? Yes ☐ No ☐

If yes, please specify:

Menstrual History: (female patient)
Age began menstruating: ____ years of age  Have never menstruated ☐

Date of last menstrual cycle: ____ Weight at that time: ____ pounds

**Child's Feeding History:**
Birth weight: ____
Any pregnancy complications? Yes ☐ No ☐
If yes, please describe:

Breast fed? ☐ How long? ____

Bottle-fed? ☐ How long? ____ Formula: ____
Early feeding problems: ____
At what age were foods first introduced?

Food allergies/intolerances as an infant/toddler? Yes ☐ No ☐
If yes, please specify:

Symptoms: ____
Has your child experienced a weight loss or weight gain in the last six months?
Yes ☐ No ☐
If yes, please describe: ____
Has your child ever dieted? Yes ☐ No ☐
If yes, how many diets has your child been on? ____

Age of first diet: ____ Weight at that time: ____ pounds
Why did your child go on the diet?

**Eating Routines:**
Please list by priority your main concerns about your child's nutritional intake:

1. ____
2. ____
3. ____
4. ____

How many times a week does your child typically eat the following meals?

Breakfast: ☐ Lunch: ☐ Dinner: ☐ Snacks: ☐

Does your family eat meals together? Yes ☐ No ☐

Which meals?

What are your child's favorite foods?

What foods does your child dislike?

How does your child react when new foods are introduced?

Does your child eat out (restaurants, take-out, fast food, etc.)?

Yes ☐ How often? ☐ No ☐

List restaurants usually chosen:

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What does your child typically drink throughout the day?

Juice ☐ Milk ☐ Water ☐ Sports Drinks ☐ Soda ☐

Does your child take lunch to school or buy lunch at school?

Examples of typical food choices:

When does your child normally snack?

Who is responsible for grocery shopping?

Who prepares/cooks the meals?

Do you read food labels? Yes ☐ No ☐

If yes, what do you look for on the label?

Does your child eat in front of the TV? Yes ☐ No ☐

Does your child eat when stressed/bored/lonely? Yes ☐ No ☐

Does your child feel bad after eating? Yes ☐ No ☐

Does your child sneak food/hide food? Yes ☐ No ☐

Does your child wish others wouldn't comment on what he/she ate?

Yes ☐ No ☐

Does your child feel like he/she eats differently than others? Yes ☐ No ☐

Please describe:

Does your child know what hunger & fullness feel like? Yes ☐ No ☐

Does your child prepare his/her own meals? Yes ☐ No ☐

Does your child avoid certain foods? Yes ☐ No ☐

Please specify: