

# Pediatric Nutrition Questionnaire

## I. Identifying Information

Child's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

## II. Medical History

Is your child allergic to any food or drinks? O Yes O No

If yes, allergic reaction to what? \_\_\_\_\_

Does he/she get a rash or edema? O Yes O No

If yes, allergic reaction to what? \_\_\_\_\_

Does your child take any vitamins/minerals or food supplements? O Yes O No

If yes, which ones? \_\_\_\_\_

If your child is not taking a vitamin, does your water supply contain fluoride? O Yes O No

Has your child had any major hospitalizations, operations, or major injuries? O Yes O No

If yes, what? \_\_\_\_\_

Does your child have any chronic illnesses? O Yes O No

If yes, what? \_\_\_\_\_

Does your child take any medications on a regular basis? O Yes O No

If yes, what medication(s) and what dosage(s)? \_\_\_\_\_

## III. Family History

	Current Age	Medical History	Cause of Death	Age at Death
Mother				
Father				
Sister				
Brother				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

(cont'd)

---

## IV. Social History

Does your child follow any special diet?  Yes  No

If yes, is your child compliant with this diet?  Yes  No

If yes, what are the special restrictions/type of diet? \_\_\_\_\_  
\_\_\_\_\_

What type of milk are you feeding your child? \_\_\_\_\_ # fl oz/day? \_\_\_\_\_

What else does your child drink during the day? \_\_\_\_\_

When did you start to introduce solid foods into his/her diet? \_\_\_\_\_

How is your child's appetite?  Excellent  Good  Fair  Poor

How many meals does your child eat during the day? \_\_\_\_\_

Does your child skip meals?  Yes  No

If yes, which ones and why? \_\_\_\_\_

How many meals away from home does your child eat every day? \_\_\_\_\_

Which meals? \_\_\_\_\_

How many snacks does your child eat during the day? \_\_\_\_\_

Does your child usually eat the food that is prepared for the family?  Yes  No

Does your child avoid any specific foods, such as milk or meats?  Yes  No

If yes, which ones? \_\_\_\_\_

Does your child chew on any of the following?

Dirt  Clay  Paint Chips  Woodwork  Ice  Plaster  Newspaper

Is your child physically active?  Yes  No

If yes, how often and what type of activity does he/she participate in? \_\_\_\_\_  
\_\_\_\_\_

What, if any, concerns do you have about your child's appetite, feeding behavior, or diet?

---

---

---