PriMED PHYSICIANS
Treating You Well.®

HEALTH HISTORY QUESTIONNAIRE

Form Completed By: _____

Date Completed: _____

Name: _____

Account #: _____

Birthdate: _____

Age: _____

HOUSEHOLD

Please list all those living in the child's home.

Name	Relationship to Child	Birthdate

Are there siblings not listed? If so, please list their names, ages and where they live. _____

_____

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home. _____

_____

BIRTH HISTORY ☐ Don't know birth history

Birth weight _____Was the baby born at term?_____ OR_____ weeks
Were there any prenatal or neonatal complications? ☐ Yes ☐ No
Explain _____
Was a NICU stay required? ☐ Yes ☐ No Explain _____
_____
Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why? _____
_____

During pregnancy, did mother: Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What_____ When _____
Was initial feeding ☐ Formula ☐ Breast Milk How long breastfed? _____
Did your baby go home with mother from the hospital? ☐ Yes ☐ No
Explain _____

GENERAL

Do you consider your child to be in good health? ☐ Yes ☐ No Explain_____
Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No Explain _____
Does your child see any specialists? ☐ Yes ☐ No Explain_____
Has your child had any surgery? ☐ Yes ☐ No Explain _____
Has your child ever been hospitalized? ☐ Yes ☐ No Explain _____
Is your child allergic to medicine or drugs? ☐ Yes ☐ No Explain_____
Do you feel your family has enough to eat? ☐ Yes ☐ No Explain_____
Has your child ever failed the following screenings? Vision: ☐ Yes ☐ No Explain_____
Hearing: ☐ Yes ☐ No Explain _____
You learn new information by: ☐ Verbal Instruction ☐ Written Instruction ☐ Pictures

BIOLOGICAL FAMILY HISTORY

Have any family members had the following?	Mother	Father	Sibling	Grandparent, Aunt or Uncle	For Office Use
Alcohol Abuse	☐	☐	☐	☐	
Anemia	☐	☐	☐	☐	
Anesthesia Problems	☐	☐	☐	☐	
Arthritis	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	
Autism	☐	☐	☐	☐	
Auto Immune Disorders (e.g. Lupus, Rheumatoid)	☐	☐	☐	☐	
Bed Wetting (after 10 years old)	☐	☐	☐	☐	
Bleeding Disorder	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	
Cardiomyopathy	☐	☐	☐	☐	
Congenital Hearing Loss	☐	☐	☐	☐	
Dental Decay	☐	☐	☐	☐	
Developmental Disability	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	
Digestive Tract Disorders	☐	☐	☐	☐	
Drug Abuse	☐	☐	☐	☐	
Epilepsy or Convulsions	☐	☐	☐	☐	
Eye Disease (e.g. Amblyopia, Lazy eye)	☐	☐	☐	☐	
Genetic or Inheritable Disease	☐	☐	☐	☐	

BIOLOGICAL FAMILY HISTORY (continued from front side)

Have any family members had the following?	Mother	Father	Sibling	Grandparent, Aunt or Uncle	For Office Use
Heart Attack/Stroke (before 55 years old)	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	
High Cholesterol, takes cholesterol medication	☐	☐	☐	☐	
Immune Problems, HIV, or AIDS	☐	☐	☐	☐	
Kidney Disease, Kidney Stones	☐	☐	☐	☐	
Learning Disability, School Failure or ADHD/ADD	☐	☐	☐	☐	
Liver Disease	☐	☐	☐	☐	
Mental Illness/Depression, or Anxiety	☐	☐	☐	☐	
Nasal Allergies	☐	☐	☐	☐	
Obesity	☐	☐	☐	☐	
Sudden Death (before 50 years old)	☐	☐	☐	☐	
Tobacco use	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	
Additional family history_____	☐	☐	☐	☐	

_____

PAST HISTORY

Does your child have, or has your child ever had.		For Office Use
Chickenpox	☐ Yes	
Frequent Ear Infections	☐ Yes	
Problems with Ears or Hearing	☐ Yes	
Nasal Allergies	☐ Yes	
Problems with Eyes or Vision	☐ Yes	
Asthma, Bronchitis, Bronchiolitis or Pneumonia	☐ Yes	
Any Heart Problem or Heart Murmur	☐ Yes	
Anemia or Bleeding Problem	☐ Yes	
Blood Transfusion	☐ Yes	
HIV	☐ Yes	
Organ Transplant	☐ Yes	
Malignancy/Bone Marrow Transplant	☐ Yes	
Chemotherapy	☐ Yes	
Frequent Abdominal Pain	☐ Yes	
Constipation Requiring Doctor Visits	☐ Yes	
Recurrent Urinary Tract Infections and Problems	☐ Yes	
Congenital Cataracts/Retinoblastoma	☐ Yes	
Metabolic/Genetic Disorders	☐ Yes	
Cancer	☐ Yes	
Kidney Disease or Urologic Malformations	☐ Yes	
Bed-Wetting (after 5 years old)	☐ Yes	
Sleep Problems; Snoring	☐ Yes	
Chronic or Recurrent Skin Problems (e.g. acne, eczema)	☐ Yes	
Frequent Headaches	☐ Yes	
Convulsions or other Neurologic Problems	☐ Yes	
Obesity	☐ Yes	
Diabetes	☐ Yes	
Thyroid or other Endocrine Problems	☐ Yes	
High Blood Pressure	☐ Yes	
History of Serious Injuries/Fractures/Concussions	☐ Yes	
Use of Alcohol or Drugs	☐ Yes	
Tobacco Use	☐ Yes	
ADHD/Anxiety/Mood Problems/Depression	☐ Yes	
Developmental Delay	☐ Yes	
Dental Decay	☐ Yes	
History of Family Violence	☐ Yes	
Sexually Transmitted Infections	☐ Yes	
Pregnancy	☐ Yes	
(For Girls) Problems with her Periods	☐ Yes	

Has had First Period ☐ Yes ☐ No Age of First Period _____

Any other significant problems _____

For Office Use Only Note:_____