Health History Questionnaire

Name: ____ Birthdate: _______________________

Who is bringing the child in today? _____________________________ Date Form Completed_______________

What is the reason for your visit today?____

List all living in the child's home and relationship to child:

Name	DOB	Relationship to Child

What is the marital status of parents? Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed ☐

What is the child's living situation if not with biological parents?

Joint custody ☐ Single custody ☐ Adoptive parents ☐ Foster family ☐

Housing: ___________________________________

Parental Education: 1) High School ☐ College ☐ Advanced Degree ☐

2) High School ☐ College ☐ Advanced Degree ☐

Parental Occupation: 1) __________________________

2) __________________________

Are there any siblings not listed? If so, please list their names and ages: ____

Birth History – fill out on first visit only

Don't know birth history☐

Birth Weight__________ Was the baby born at term? ☐Yes ☐ No

Were there prenatal or neonatal complications? ☐Yes ☐ No

Explain: ____

Was a NICU stay required? ☐Yes ☐ No Explain: _____________

____

Was the delivery: ☐ Vaginal ☐Cesarean – Why? _____________

____

During pregnancy, did mother:

Use Tobacco? ☐Yes ☐ No Drink Alcohol ☐Yes ☐ No

Use Drugs or Medication? ☐Yes ☐ No

When _______ What___________

Use prenatal vitamins? ☐Yes ☐ No

Was initial feeding Formula☐ Breast Milk ☐

How long breast fed? _____________________

Did your baby go home with mother from 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 your feel your family has enough to eat? ☐Yes ☐No Explain: ____

Has your child ever failed the following screenings? Vision/Hearing ☐Yes ☐No Explain: ___________________________________

Language spoken in home. ____

Are there any religious or cultural beliefs that you want considered regarding your child's healthcare? ☐Yes ☐No

Explain: ____

You learn new information by: Verbal instruction ☐ Written instruction ☐ Pictures ☐

Current medication____

Child's Current and Past History

☐Problems with Eyes/Vision
☐Congenital Cataracts/Retinoblastoma
☐Frequent Ear Infections
☐Problems with ears or hearing
☐Nasal allergies
☐Frequent Strep
☐ Heart Problem or Murmur
☐Asthma/Reactive airway Disease
☐Bronchiolitis
☐Pneumonia
☐Constipation requiring doctor visit
☐Frequent Abdominal Pain
☐Recurrent Urinary Tract Infections/Prob
☐Kidney disease/Urologic Malformations
☐Bedwetting after age 5

☐Frequent Headaches
☐History of Concussion
☐Seizures/other neurologic problems
☐Developmental Delay
☐ADHD
☐Anxiety/Depression
☐Mood Disorder
☐Anemia/Bleeding/Clotting Disorder
☐Blood Transfusion
☐Cancer
☐Chemotherapy/Bone Marrow Transplant
☐Organ Transplant
☐Obesity
☐High Blood Pressure
☐Chronic/Recurring Skin issues (Acne/Eczema)

☐Diabetes/Thyroid
☐Metabolic/Genetic Disorder
☐Chicken Pox
☐History Serious Injuries/Fractures
☐Sleep Problems; Snoring
☐Dental Decay
☐Use of Alcohol/Drugs/Tobacco
☐Sexually Transmitted Infections/HIV
☐History of Family Violence

Girls:

☐Problems with Periods
☐Pregnancy
☐Has had first period
Age of first period_________

Any other Significant Problems: ____ Phy. Sig: ______________________

Biological Family History Patient Name: ____________________________ DOB: ______________

Have any family members had the following?

	Mother	Father	Siblings	Mother's Parent	Father's Parent	Aunt/Uncle	Patient's Child
Alcohol Abuse							
Anemia							
Anesthesia Problems							
Arthritis							
Asthma							
Autism							
Autoimmune Disorder (Lupus/Rheumatoid)							
Bedwetting after age 10							
Bleeding/Clotting Disorder							
Cancer							
Cardiac Arrhythmias							
Cardiomyopathy							
Congenital Hearing Loss							
Dental Decay							
Developmental Disability							
Diabetes							
Digestive Tract Disorders							
Drug Abuse							
Epilepsy/Convulsions							
Eye Disease (Amblyopia/Lazy Eye)							
Gastroesophageal Reflux							
Genetic or Inheritable Disease							
Heart Attack before age 55							
High Blood Pressure							
High Cholesterol or Triglycerides							
Immune Problem, HIV, AIDS							
Inflammatory Bowel disease (Crohn's/Ulcerative Colitis)							
Kidney Disease							
Kidney Stones							
Learning Disability/School Failure/ADD/ADHD							
Liver Disease							
Mental Illness /Depression/Anxiety							
Nasal Allergies							
Obesity							
Stroke before age 55							
Sudden Death before age 50							
Thyroid Disease							
Tobacco Use							
Tuberculosis							

Additional Family History:

____ Phy. Sig.________________________