Complete following information about your Child

HEALTH QUESTIONNAIRE

Name _____ Today's Date _____

Date of Birth _____ Age: _____ Height: _____Weight:_____

Allergies (Drug, Food, Seasonal, etc.):

_____

_____Type of Reaction(s):_____

Newborn History: Born Full Term? Y N wks.:_____ Delivery Type: Vaginal or C-Section

Any complications during pregnancy or birth? _____

Surgeries and Hospitalizations:

Year	Illness/Operations
_____/	_____
_____/	_____
_____/	_____
_____/	_____

Past Medical History

Has your child had any of the following?

Aids or HIV	Y N	Epilepsy /Convulsions/Neurologic Problems	Y N
Anemia	Y N	Heart disease/ Heart Murmur	Y N
Arthritis	Y N	High Blood Pressure	Y N
Asthma/Wheezing	Y N	Hives	Y N
Bladder Infection	Y N	Kidney Disease	Y N
Bleeding tendency	Y N	Migraines/Frequent Headaches	Y N
Cancer	Y N	Thyroid Disease	Y N
Chicken Pox	Y N	Transfusions	Y N
Diabetes	Y N	Tuberculosis	Y N
Eczema/Skin Problems	Y N	Use Alcohol or Drugs	Y N
Serious injuries/accidents	Y N	Mental Illness (ADHD, Depression, Anxiety etc.)	Y N

Any other Diseases_____

Has your child seen any Specialist in the Past? (I.e. Cardiology, Endocrinology, Counselor) Y N

_____

Current Medications	**Dosage**	**Times/Day**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please complete both sides of this form

Revised 6/2014

Family History:
Have any blood relatives (<u>child's sibling, parents or grandparents</u>) had any of the following?
Please specify whose side of the family: <u>Mothers/Maternal or Fathers/Paternal</u>

	Y	N	Family Member		Y	N	Family Member
Allergies				Heart Disease			
Anemia				Heart Attack			
Asthma				Kidney Disease			
Deafness				High Cholesterol			
Cancer				Stroke			
Diabetes				Thyroid Disease			
Epilepsy/Seizures				Tuberculosis			
Mental Illness				Alcohol Abuse			
Liver Disease				Drug Abuse			
Bleeding Disorder				Mental Retardation			
High Blood Pressure				Immune Deficiency (HIV or AIDS)			

Any other pertinent family medical information or history?

_____

_____

_____

Social History:

Child's home: House/apartment/trailer/other _____ (circle one)
Approximate year home built _____ (if known)
Who lives with child? Mom Y N
Dad Y N
Is noncustodial parent involved? Y N
<u>List ALL others in home:</u> _____ _____
_____ _____
_____ _____
Pets/animals in home Y N Type _____
Guns in home Y N *if so, are they kept locked & unloaded? Y N
Smoke in home/outside/car (circle all that apply) Packs per day _____
Alcohol Y N Drinks per week _____
Illegal drugs Y N Type: _____ Frequency: _____week/day

Adolescent Girls Only:

Age at onset of menses _____
Date of last menses _____
Use of Birth Control: Y N Type _____
Number of Pregnancies _____
Year of last Pap Smear _____
History of Sexually Transmitted Diseases Y N Type _____ Year _____

Please complete both sides of this form

Revised 6/2014