Health History Questionnaire

Physicians To Children

All the information that you provide in this questionnaire is strictly confidential and will become part of your medical record.

Date: Chart #

Patient/Family Information

Patient Name: (First/MI/Last)		M	F	**Date of Birth:** (mm/dd/yyyy)
	Sex	❍	❍	

Marital Status of Parents:

- ❍ Single
- ❍ Partnered
- ❍ Married
- ❍ Separated
- ❍ Divorced
- ❍ Widowed

If separated/divorced, what is the patient's custody status? _____.

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

_____.

Are there siblings living away from home? ❍ Yes ❍ No

List all family members living in the patient's home:

Name:	Date of Birth:	Relation:

Your Child's Health History

Are immunizations up to date? ____ Yes ____ No Date of Last Exam: _____ Previous/Referring Doctor: _____

Do you consider your child to be in good health? ____ Yes ____ No If no, explain: _____

List all medicines that the patient is currently taking (Include medicines such as prescribed drugs, over-the-counter drugs, vitamins, and inhalers):

_____

Review of Systems and Past Medical History

Does the *PATIENT* have or ever had any of the following:	**Yes**	**No**	**Explain**
a serious medical condition/problem?			
been hospitalized or had surgery?			
had a serious injury or accident?			
chicken pox? When? _____			
allergies, asthma, bronchitis, respiratory infections?			
repeated ear infections, tubes, difficulty with hearing?			
problems with eyes or vision?			
heart problems or a heart murmur?			
anemia, bleeding problems or blood transfusion?			
abdominal pain, constipation requiring doctor visits?			
recurrent vomiting, recurrent diarrhea, blood in stools?			
bladder or kidney infections, bed-wetting after 5 yrs.?			
recurrent skin problems (acne, eczema, etc.)			
headaches, convulsions, other neurologic problems?			
diabetes, thyroid or other endocrine problems?			
If female, has she started her menstrual periods? If yes, LMP ___/___/___ Any problems?			

Pregnancy

Did the mother smoke, use drugs or alcohol during pregnancy? ___ Yes ___ No

Check if the mother had any of the following problems: ___ excessive wt. gain ___urinary infections ___excessive swelling ___ toxemia ___rubella ___venereal disease ___other ___no problems

Birth

Weight: _____ Length: _____ Apgar: _____ Was baby born at: _____Term _____Early _____Late

If early, how many weeks' gestation: _____ Was labor difficult or prolonged? _____Yes _____No

Was delivery difficult or complicated? _____ Yes _____ No

Newborn

Check if the patient had any of the following problems: ___ feeding problems ___slow weight gain ___blood in stools ___multiple formula changes ___ colic ___jaundice ___ recurring vomiting ___recurring diarrhea Feeding: ___ Formula ___ Breast

Development

Are you concerned about the patient's:

1. physical development? ☐ Yes ☐ No _____
2. mental or emotional development? ☐ Yes ☐ No _____
3. learning ability? ☐ Yes ☐ No _____
4. attention span or activity level? ☐ Yes ☐ No _____

If in school, has the patient had:

1. tutoring outside of classroom? ☐ Yes ☐ No _____
2. placement in a special or resource class? ☐ Yes ☐ No _____
3. to repeat a grade? ☐ Yes ☐ No _____
4. educational or psychological testing? ☐ Yes ☐ No _____
5. behavioral problems? ☐ Yes ☐ No _____

Family Health History

If a family member has or has had any of the following problems, check the appropriate box for the family member:

Diagnosis	Mother	Father	Sister	Brother	Mat Gmother	Mat Gfather	Pat GMother	Pat Gfather	Other
ADD/ADHD									
Allergies									
Asthma									
Birth Defects									
Cancer									
Celiac Disease									
Colitis/Ulcerative Colitis/Crohn's									
Coronary Artery/Heart Disease									
DDH (Hip Dysplasia)									
Deafness									
Depression									
Developmental Delay									
Diabetes									
Eczema									
Genetic Disorder									
Hemoglabinopathy (Blood Disorders)									
Hypertension									
Learning Disability									
Mental Illness									
Mental Retardation									
Migraines									
Obesity									
Scoliosis									
Seizure Disorder									
SIDS									
Strabismus (Visual Problems)									
Thyroid Disease									
Other:									

Other

Problems/Concerns: _____

_____

Form Completed By: _____ **Relationship to Patient:** _____

Provider Signature: _____ **Provider Review Date:** _____