PEDIATRIC HEALTH HISTORY QUESTIONNAIRE (AGES 0-17)

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ **M** ☐ **F**	**DOB:**	
Previous or referring doctor:				

Allergies /Sensitivies	**Reaction**

List your prescribed medications and over-the-counter medications

Name the Medication	Strength	Frequency Taken

HEALTH HABITS AND PERSONAL SAFETY

Living with:	
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drinks ☐ Other
	# of ounces per day?
Alcohol	Do you drink alcohol? ☐ Yes ☐ No
	If yes, what kind?
	How often?
Tobacco	Do you use tobacco products? ☐ Yes ☐ No Age or year you started: Age or year you quit:
	☐ Cigarettes – pks./day: ☐ E cigs –#/day: ☐ Chew - #/day: ☐ Pipe - #/day: ☐ Cigars - #/day
	Exposure to second-hand smoke? ☐ Yes ☐ No
Drugs	Do you currently use recreational or street drugs? (please specify) ☐ Yes ☐ No
	Method of use (injection, inhalation, etc)? ☐ Yes ☐ No
Exercise	☐ Sedentary/No exercise
	☐ Yes Minutes/Day:_____ Days/Week:_____ Type of Exercise:_____.

PERSONAL HEALTH HISTORY

Have you <u>ever</u> had any of the following medical problems? Please check the corresponding box.

	<u>Date Diagnosed</u>		<u>Date Diagnosed</u>		<u>Date Diagnosed</u>
Allergy/Immunology: ☐ Seasonal Allergies Cancer: ☐ Cancer; Type:_____. Infectious Disease: ☐ HIV/AIDS ☐ Tuberculosis/Positive TB Test HEENT: ☐ Hearing Problems ☐ Sinus Issues (chronic) Respiratory: ☐ Asthma Cardiovascular: ☐ Heart Murmur		Musculoskeletal: ☐ Fractures ☐ Sprains Gastroenterology: ☐ GERD ☐ Hepatitis: ☐A ☐B ☐C (specify) ☐ Hernia; Type:_____. Neurology: ☐ Epilepsy ☐ Headaches Genitourinary: ☐ Kidney/Bladder Problems Psychiatry: ☐ Anxiety ☐ Chemical Dependence ☐ Depression		Endocrine: ☐ Diabetes, Type 1 ☐ Diabetes, Type 2 ☐ Thyroid Problems ☐ Weight Gain ☐ Weight Loss Hematology: ☐ Anemia ☐ Bleeding/Clotting Disorders Congenital Abnormalities: ☐ Cerebral Palsy Skin: ☐ Psoriasis/Eczema ☐ Acne ☐Other:	

Surgeries/Hospitalizations		
Date	Procedure/Reason	Hospital

FAMILY HEALTH HISTORY

PLEASE SPECIFY IF INDIVIDUALS ARE LIVING OR DECEASED. ALSO INDICATE MATERNAL OR PATERNAL GRANDPARENTS.

☐ ADOPTED

Condition	Father	Mother	Sibling	Grand-parent	**Condition**	Father	Mother	Sibling	Grand-parent
Alcoholism					Epilepsy				
Allergies					Heart Problems				
Anxiety					High Blood Pressure				
Arthritis					High Cholesterol				
Asthma/Hay Fever					Kidney Disease				
Birth Defects					Leukemia				
Cancer (Breast)					Liver Problems				
Cancer (Prostate)					Migraines				
Cancer (specify)					Obesity				
Colon/Bowel Problems					Stomach Ulcers				
Depression					Stroke				
Diabetes					Other:				
Emphysema/COPD									

PREVENTATIVE CARE

Date of Last Preventative Exam:

Please bring a copy of your child's complete vaccination record to the first appointment.

BIRTH HISTORY

Obstetrician/Midwife:

Birth location: ☐ Home ☐ Hospital/Birth Center Specify hospital or birth center location:

Birth Weight:	**Birth Length:**	**Birth Head Circumference:**
Multiples birth: ☐ Yes ☐ No	**Abnormal PKU: ☐ Yes ☐ No Please Explain:**	

Complications during pregnancy or at birth? ☐ Yes ☐ No Please explain below:

Printed Name of Legal Guardian:	Date:
Signature of Legal Guardian:	