

Child Health Questionnaire

Name _____ Date of Birth _____ Today's Date _____
 Age _____ Male ___ Female ___ Grade in School _____ Religion _____
 Previous M.D. _____ Location _____

Past, Ongoing or Recurrent Medical Problems		Past Surgeries/Hospitalizations	
Diagnosis	Year	Diagnosis	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Medications			
Medication	Dose(strength)	Frequency	Reason Taken
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Nutritional/Herbal Supplements: _____
 Other Treatments: (Please circle all that apply) Naturopathy, Chiropractic, Midwifery, Acupuncture, Others, For Example: Chinese Medicine, Curandero, Herbs etc... _____

Medication Reactions/Allergies (please include creams, pills, injections, drops, latex, iodine etc..)			
Medication	Reaction	Medication	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

<u>Immunizations</u>			<u>Past Infections</u>			<u>Past Exams</u>		
	Y/N	Year		Y/N	Year		Y/N	Year
Standard childhood	/	_____	Chickenpox	/	_____	Eye Exam	/	_____
Influenza	/	_____	Tuberculosis	/	_____	Hearing Exam	/	_____
Hepatitis A (food borne)	/	_____	Rheumatic fever	/	_____	Speech Eval	/	_____
Hepatitis B (blood borne)	/	_____	Hepatitis	/	_____	Pelvic/PAP	/	_____
Tetanus (last)	/	_____	Pneumonia	/	_____			
Pneumonia	/	_____	Pelvic infection	/	_____			
MMR(Measles,Mumps,Rubella)	/	_____						

Girls: Menstruation? Y ___/N ___ Age at first period: _____

Family History of Diseases

Immediate Family (Please below if any blood relatives have had the following problems: Mother-M, Father-F, Sister-S, Brother-B, Grandmother-GM, Grandfather-GF, Aunt-A, Uncle-U, Cousin-C)

Age	Disease (if any)	Diabetes Y ___/N ___	Relation: _____	Heart disease Y ___/N ___	Relation: _____
Father _____	_____	Stroke Y ___/N ___	Relation: _____	Hypertension Y ___/N ___	Relation: _____
Mother _____	_____	Cancer Y ___/N ___	Relation: _____	Tuberculosis Y ___/N ___	Relation: _____
Bro/Sis _____	_____	Epilepsy Y ___/N ___	Relation: _____	Arthritis Y ___/N ___	Relation: _____
Bro/Sis _____	_____	Thyroid Y ___/N ___	Relation: _____	Alcoholism Y ___/N ___	Relation: _____
Bro/Sis _____	_____	Bleeding Y ___/N ___	Relation: _____	Colon cancer Y ___/N ___	Relation: _____
Bro/Sis _____	_____	Kidney Y ___/N ___	Relation: _____	Mental illness Y ___/N ___	Relation: _____
Bro/Sis _____	_____	Other: _____			

Social History: (Please check all that apply)

Lives With:

- Father
- Mother
- Stepfather
- Stepmother
- Brother(s) how many? ____
- Sister(s) how many? ____
- Grandparents
- Guardian
- Other Adults _____
- Other Children _____
- If divorced/separated do the parents share custody of the child?

Development:

- Delay in learning, walking, talking or speech? If known, please state _____
- Attending school at expected grade level? If not, please state _____
- Grades in School? _____ better average lower
- Other Interests: _____
- Is the child's diet high __, moderate __ or low __ in fat?
- Child has been:
- Exposed to household member(s) smoking inside __/outside __
- Exposed to alcoholism/drug abuse in household member(s)
- Exposed to lead (paint older than 1980, gas stations, remodeling)
- Consuming caffeinated products, (chocolate, cola drinks, coffee, tea, caffeine pills)
- Traveling outside the US? If so please state where _____
- Sniffing glue or other products

Birth:

Were there problems in the mother's pregnancy? Y __ N __ Please state _____
Was the child's birth normal __ or did complications occur __, ? If so please specify _____

Safety:

- Does the child use a car seat, booster seat or seat belt at all times?
- While biking or on a scooter does the child use a helmet? N/A
- Does the child cross the street properly? N/A
- Have you talked to your child about strangers? If so, at what age? _____
- Has your child been involved in a serious or traumatic accident? If so, please state _____

Systems Review: Have you been bothered a significant amount by any of the problems below presently or in the past? (Please all that apply.)

General:

Constant fatigue Y __/N __
Anemia Y __/N __

Eyes:

Decreased vision Y __/N __
Glasses/Contacts Y __/N __
Glaucoma Y __/N __

Ears:

Hearing loss Y __/N __
Recurrent ear infections Y __/N __
Ringing in ears Y __/N __

Head:

Frequent headaches Y __/N __
Dizziness Y __/N __

Nose/Throat:

Hayfever Y __/N __
Recurrent sinus infections Y __/N __
Severe snoring Y __/N __

Skin:

Changing moles Y __/N __
Chronic rash Y __/N __
Skin growths Y __/N __

Heart:

Shortness of breath Y __/N __
Chest pain Y __/N __
Palpitations Y __/N __
Murmur Y __/N __

Lungs:

Wheezing/asthma Y __/N __
Chronic cough Y __/N __
Coughing up blood Y __/N __

Stomach:

Frequent pain/heart burn Y __/N __
Recurrent diarrhea Y __/N __
Blood in stool Y __/N __
Hemorrhoids Y __/N __

Urinary:

Decreased flow or control Y __/N __
Painful/ frequent urination Y __/N __
Blood in urine Y __/N __
Kidney stones Y __/N __

Musculo-Skeletal:

Joint pain or swelling Y __/N __
Arthritis/gout Y __/N __

Nervous System:

Convulsions Y __/N __
Fainting spells Y __/N __

Genital:

Sexual diseases Y __/N __
Vaginal/penile discharge Y __/N __
Sexual problems Y __/N __

Menstrual:

Heavy/painful periods Y __/N __
Abnormal PAP smear Y __/N __

Mental Health:

Excessive worry/anxiety Y __/N __
Excessive moodiness/depression Y __/N __
Alcohol/chemical dependence Y __/N __

Other: (please list)

Additional questions for the doctor:

Signature: _____

Relationship to Patient: _____