



Dear Parent:

This is a health questionnaire on your child. **Please complete this form, and bring it with you at the time of an appointment.**

Date Completed: _____

Child's Name: _____ Date of Birth: _____

Contact Information for Parent 1

Name: _____ Email: _____

Home Address: _____

Home Phone: _____ Cell/Other: _____

Contact Information for Parent 2

Name: _____ Email: _____

Home Address: _____

Home Phone: _____ Cell/Other: _____

This child lives with:

- Mother
- Father
- Mother/Father
- Mother/Partner
- Father/Partner
- Grandparent/Other

FAMILY HISTORY

1. Parent 1 Name: _____
 Age: _____ Current Health: _____
 Past Health Problems: _____
 Ethnicity: _____

2. Parent 2 Name: _____
 Age: _____ Current Health: _____
 Past Health Problems: _____
 Ethnicity: _____

3. Marital Status of Parents: _____

4. Other Children in Family:

<u>Date of Birth</u>	<u>Gender</u>	<u>Name</u>	<u>Healthy or Medical Issues?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Are there cultural or religious practices that might affect your child's medical care? Yes No
 If yes, please explain (e.g., blood transfusion, dietary rules, etc.): _____

6. Is there tobacco use in/around your household? Yes No

7. Is there a history in the **family/a blood relative** of:

a. Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, state relationship to child
b. Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
c. Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
d. Birth Defects/Genetic Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____



- e. Cancer
 - i. Brain Yes No _____
 - ii. Breast Yes No _____
 - iii. Colon Yes No _____
 - iv. Ovarian Yes No _____
 - v. Skin Yes No _____
 - vi. Thyroid Yes No _____
 - vii. Other (describe and state relationship to child): _____
- f. Depression Yes No _____
- g. Diabetes Yes No _____
- h. Hearing Loss Yes No _____
- i. Heart Attack Yes No _____
- j. Heart Disease Yes No _____
- k. Hepatitis Yes No _____
- l. High Blood Pressure Yes No _____
- m. High Cholesterol Yes No _____
- n. Learning Disability Yes No _____
- o. Mental Illness Yes No _____
- p. Seizures Yes No _____
- q. Thyroid Problems Yes No _____
- r. Tuberculosis Yes No _____

PRENATAL & BIRTH HISTORY

1. Any prenatal complications? Yes No
2. Was the child full term? Yes No
3. Where was the child born? _____
4. What was the method of delivery?
 - Breech
 - Caesarean (please state reason):
 - Forceps
 - Spontaneous vaginal
5. Child's birth weight: _____
6. During the hospital stay, did the child have any of the following:
 - Antibiotic treatment Yes No
 - Blue spells Yes No
 - Convulsions Yes No
 - Jaundice Yes No
 - Skin rash Yes No
 - Did child remain in hospital longer than mother? Yes No



7. How was/is baby fed?
- Bottle
- Breast

DEVELOPMENTAL HISTORY

1. Has your child had any developmental delays? Yes No
2. Does your child receive any developmental services? Yes No
If yes, name of location: _____

IMMUNIZATIONS

**PLEASE GIVE US A COPY OF PREVIOUS IMMUNIZATIONS/VACCINES
And TB (Tuberculosis) Testing or BCG Vaccination**

PAST MEDICAL HISTORY

1. Has the child had:
- a. Blood: anemia (iron deficiency, Sickle cell, Thalassemia) Yes No
 - b. Blood transfusions Yes No
 - c. Chicken pox (Varicella) Yes No
 - d. Contusions Yes No
 - e. Convulsions Yes No
 - f. Fractures Yes No
 - g. German Measles (Rubella) Yes No
 - h. Hospitalizations Yes No
 - i. Measles (Rubeola) Yes No
 - j. Meningitis Yes No
 - k. Mumps Yes No
 - l. Operations Yes No

If yes, what illness? _____

- m. Poison ingestion Yes No

- n. Other serious medical illnesses Yes No

If yes, what kind? _____

- o. Is your child currently taking any medications, vitamins or herbs? Yes No

<u>Medication</u>	<u>Strength/Dose</u>	<u>How Often?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

- p. Reaction to medication or food (allergy) Yes No

If yes, please explain: _____



q. Any chronic or recurring pain? Yes No

If yes, please explain: _____

2. Eyes:

- a. Any visual problems? Yes No
- b. Do eyes look crossed? Yes No
- c. Does the child wear eyeglasses? Yes No

3. Ears:

- a. Any hearing problems? Yes No
- b. Three or more ear infections? Yes No

4. Nose:

- a. Frequent sneezing attacks or rubbing his/her nose? Yes No
- b. Frequent nose bleeds? Yes No

5. Throat:

- a. Three or more strep throat infections per year? Yes No

6. Heart:

Have you ever been told your child has:

- a. A heart murmur? Yes No
- b. A heart defect? Yes No
- c. High blood pressure? Yes No

7. Lungs:

Has your child ever had:

- a. Asthma/wheezing? Yes No
- b. Bronchitis or pneumonia? Yes No
- c. Chronic cough? Yes No

8. Does your child tire easily? Yes No

9. Abdomen:

Has your child ever had:

- a. Blood in bowel movement? Yes No
- b. Difficulty with appetite or eating? Yes No
- c. Frequent abdominal pain? Yes No
- d. Frequent vomiting or diarrhea? Yes No
- e. Jaundice? Yes No
- f. Marked weight loss? Yes No

If yes, please explain: _____

10. Kidney:

- a. Does your child ever complain of burning or frequency of urination? Yes No
- b. Does your child wet the bed? Yes No
- c. Has there ever been blood in the urine? Yes No
- d. Has your child ever had a urinary tract infection? Yes No



11. Skin:

- a. Acne? Yes No
- b. Any sensitivity or allergy? Yes No
- c. Eczema or atopic dermatitis? Yes No

12. Extremities:

Has your child ever had:

- a. Weakness or paralysis of arms or legs? Yes No
- b. A persistent limp? Yes No
- c. Ever worn corrective shoes or braces? Yes No

13. Neurological:

Has your child ever had:

- a. Breath holding? Yes No
- b. Convulsions or seizures? Yes No
- c. Dizziness? Yes No
- d. Fainting? Yes No
- e. Frequent headaches? Yes No
- f. Temper tantrums? Yes No

14. Is your child:

- a. Impulsive? Yes No
- b. Lacking in self-control? Yes No
- c. Overactive? Yes No
- d. Does your child have problems with:
 - i. Attending school? Yes No
 - ii. Attention span? Yes No
 - iii. Learning? Yes No
 - iv. Mood? Yes No
 - v. Parents? Yes No
 - vi. Peers? Yes No
 - vii. Siblings? Yes No
 - viii. Sleep? Yes No
- e. Are there concerns about physical, sexual or emotional abuse? Yes No

15. Has your child begun puberty? Yes No

16. Any other concerns you would like to discuss? _____

Parent Signature

Date

Provider Name

Date Reviewed