Health History Questionnaire

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CHILD HISTORY (age 0-11)

CHILDS NAME:	DATE OF BIRTH:	AGE:	DATE:
MOTHER's NAME:	DATE OF BIRTH:	OCCUPATION:	
FATHER's NAME:	DATE OF BIRTH:	OCCUPATION:	
Address:			Phone:

BROTHERS NAME	BIRTHDATE	*SISTERS* NAME	BIRTHDATE
____________________	__________	____________________	__________
____________________	__________	____________________	__________
____________________	__________	____________________	__________
____________________	__________	____________________	__________

CHILD MEDICAL HISTORY

Has THIS child had any…… (If YES, explain on back)

- Y N Problems after delivery?
- Y N Serious illnesses or growth problems?
- Y N Serious Accidents? Head Trauma? Broken Bones?
- Y N Hospitalizations? ____________________
- Y N Surgeries? ____________________
- Y N Recurrent Infections? (Ear, throat or lung functions)
- Y N Allergies, Asthma?
- Y N Chicken Pox? What Year? ____________
- Y N Bladder infection, kidney problems, undescended Testicles, bed wetting?
- Y N Seizures?
- Y N Serious dental problems?
- Y N Serious reaction to immunization?
- Y N Learning or developmental problems?
- Y N Speech, hearing or vision problems?
- Y N Emotional / Behavioral problems?
- Y N Has this child been hit, slapped, kicked or Otherwise physically hurt by someone?

Does THIS child…..

- Y N Wear glasses?
- Y N Take any medications?
- Y N Take any vitamins?
- Y N Take any Fluoride?

Where has child gone for prior medical care?

____

Date of last Dental Exam? ____________________

Date of last Medical Exam? ____________________

FAMILY MEDICAL HISTORY

Have these health problems occurred in the child(s) family? (Including child's natural parents, brothers, sisters, and grandparents)

			Relationship
Y	N	Allergies/Asthma/Lung Disease?	__________
Y	N	Tuberculosis?	__________
Y	N	Blood Problems?	__________
Y	N	Diabetes?	__________
Y	N	Thyroid Disease?	__________
Y	N	Cancer Type:__________	__________
Y	N	Birth Defect:__________	__________
Y	N	Drug / Alcohol Abuse?	__________
Y	N	Mental illness / Depression / Suicide Attempt ______________________________	
Y	N	Glaucoma?	__________
Y	N	Heart Disease / Heart Attacks	__________
Y	N	High Blood Pressure?	__________
Y	N	High Cholesterol?	__________
Y	N	Stroke?	__________
Y	N	Kidney Disease?	__________
Y	N	Migraines?	__________
Y	N	Seizures?	__________
Y	N	Obesity?	__________
Y	N	Has any family member died suddenly at less than 50 years of age of causes other than an accident? ______________________________	

Other: ____________________ __________

Other: ____________________ __________

MOTHER's PREGNANCY HISTORY WITH THIS CHILD

What month of pregnancy did you begin Prenatal Care?

____

Where? ____

Pregnancy History:

Number of Pregnancies _______________________________

Number of Live Births ________________________________

Number of Miscarriages ______________________________

Number of Abortions _________________________________

Problems of pregnancy, labor, delivery __________________

____

Type of Delivery: **VAGINAL** **C-SECTION**

How long was your babies hospital stay? ____________ days

CHILD's SOCIAL HISTORY

Child lives with: ____ MOTHER

____ FATHER

____ # SIBLINGS

____ # OTHERS

Who is the child's primary caretaker? ___________________

Name of School/Daycare; ____________________________

Grade: ____________________________

Social Service agencies involved with your family:__________

____

Does Physcial Abuse occur in your home? **Y N**

Does Verbal Abuse occur in your home? **Y N**

FEMALES ONLY (if applies)

Age of first Period: _____ Last Menstrual Period:__________

Number of Days between Periods:

Y N Cramps?

Y N Bleeding between Periods?

Y N Has child ever had a Pelvic or Internal Vaginal Exam? Reason: ___________________________

BEHAVIOR / PERSONAL HISTORY

Y N Do you have any concerns about your childs behavior?

Y N Do you have concerns about how your child is developing or learning?

Y N Are you satisfied with how your child is doing in school?

Y N Does your child seem generally happy?

HEALTH / NUTRITION HABITS

Y N Do you have any concerns about your childs diet, eating habits or growth?

Y N Does your child receive WIC?

Y N Are there smokers in your home?

Y N Do you have concerns that your child may be using Tobacco, alcohol or street drugs?

Childs favorite physical activity / exercise: _________________

____

Number of hours a day spent watching TV…

___ 0-1 ___ 1-2 ___3+

Number of times child is read to each week…

___ 0-1 ___ 1-2 ___3+

Number of days missed school last year: _______________

SAFETY

Y N Do you have Syrup of Ipecac in your home?

Y N Does child use a car seat or seat belt?

Y N Does child wear a helmet when biking or skating?

Y N Is child alone at home after school?

Y N Do you have a working smoke detector at home?

Y N Is there a gun in your home?

Is the child **currently taking** any **Medications**? **Y** (list below) **N**

Medication	Dose	How many times per day?	When Started?

Comments / Explanations

____

____

____

____