



Patient's Name
MRN
DOB

HEALTH QUESTIONNAIRE

Patient Name: _____ Date: _____

Age: _____ DOB: _____

PARENT: Please fill out this form. Explain any "yes" answers in the space provided.

Mother's Name: _____ Age: _____ Occupation: _____

Father's Name: _____ Age: _____ Occupation: _____

Sibling Name: _____ Age: _____ Sibling Name: _____ Age: _____

Sibling Name: _____ Age: _____ Sibling Name: _____ Age: _____

BIRTH HISTORY				If yes, explain
Pregnancy	Complications during pregnancy (infection, baby too small, poor movements)?	Yes	No	
Delivery	Was the baby premature?	Yes	No	
Birth Weight _____ Place of Birth _____	Any complications after birth (jaundice, breathing, feeding problem, infection)?	Yes	No	
	Age of first bowel movement _____?			
HOSPITALIZATIONS	Please list below any overnight hospitalizations.			
	Age			

SURGERIES	Please list below any surgeries.			
	Age			

MEDICAL HISTORY	Please list below any serious illnesses or injuries.			
	Age			

ALLERGIES	Is your child allergic to any medications, foods, or environmental agents?	Yes	No	Please list:

Patient Name: _____

PRESENT MEDICATIONS	Please list below any present medications your child is now taking or takes often. Please include prescription medications, over the counter medications or herbs.	
	Name	Dosage
	_____	_____
	_____	_____
	_____	_____

REVIEW OF SYSTEMS

Please check any symptoms which are **currently** a problem for your child.

GENERAL:			
<input type="checkbox"/> Fevers	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Fatigue
ALLERGY/IMMUNOLOGY:			
<input type="checkbox"/> Allergies	<input type="checkbox"/> Frequent Infections	<input type="checkbox"/> Immune Problems	
EYES:			
<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Wears Glasses	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Double Vision
CARDIOVASCULAR:			
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Abnormal Blood Pressure	<input type="checkbox"/> Palpitations
GENITOURINARY/GYN:			
<input type="checkbox"/> Pain or Burning with Urination	<input type="checkbox"/> Blood in Urine		
<input type="checkbox"/> Frequent Urge to Urinate	<input type="checkbox"/> Urinary Incontinence		
<input type="checkbox"/> Bedwetting After Toilet Trained	<input type="checkbox"/> Age of Onset of Menstrual Periods _____		
<input type="checkbox"/> First Day of Last Period	<input type="checkbox"/> On Birth Control Pills		
HEENT:			
<input type="checkbox"/> Earache	<input type="checkbox"/> Ear Drainage	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Sore Throats	<input type="checkbox"/> Mouth Ulcers	<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Painful Swallowing			
PULMONARY:			
<input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Asthma	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Apnea			
DERMATOLOGIC:			
<input type="checkbox"/> Skin Rashes	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Excessive Itching	
HEMATOLOGIC:			
<input type="checkbox"/> Anemia	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> History of Blood Transfusions	
<input type="checkbox"/> Enlarged Lymph Nodes			
ENDOCRINE:			
<input type="checkbox"/> Poor Growth	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Abnormal Menstrual Periods	

Patient Name: _____

GASTROINTESTINAL:	
<input type="checkbox"/> Stomachaches:	When did pain begin? _____ Frequency? _____ Location of pain? _____ Severity on scale of 1-10 (10 is most severe)? _____ Wakes child up? <input type="checkbox"/> Yes <input type="checkbox"/> No Worse during school? <input type="checkbox"/> Yes <input type="checkbox"/> No Worse with dairy products? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list aggravating factors: _____ _____
<input type="checkbox"/> Liver Problem	_____
<input type="checkbox"/> Constipation	_____
<input type="checkbox"/> Frequency of BM	_____
<input type="checkbox"/> Diarrhea	Age of onset? _____
<input type="checkbox"/> Blood in Stool	Mixed in stool or outside? _____
<input type="checkbox"/> Soiling Undergarments	Age of onset? _____
<input type="checkbox"/> Vomiting	If yes, green bile? _____ If yes, Blood? _____
<input type="checkbox"/> Heartburn	_____
<input type="checkbox"/> Nausea	_____
MUSCULOSKELETAL:	
<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Muscular Weakness <input type="checkbox"/> Scoliosis
NEUROLOGIC:	
<input type="checkbox"/> Headaches	<input type="checkbox"/> Seizures <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Dizziness
<input type="checkbox"/> Fainting	<input type="checkbox"/> ADHD <input type="checkbox"/> Decreased Sensation
PSYCHIATRIC:	
<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety <input type="checkbox"/> Poor Sleep <input type="checkbox"/> Panic Attacks
<input type="checkbox"/> Poor Appetite	

FAMILY HISTORY:		
Please indicate if any family members suffer from the following illnesses. Use the following abbreviations to indicate which family member is effected.		
M = Mother	PA = Paternal Aunt	MGM = Maternal Grandmother
F = Father	PU = Paternal Uncle	MGF = Maternal Grandfather
S = Sister	MA = Maternal Aunt	PGM = Paternal Grandmother
B = Brother	MU = Maternal Uncle	PGF = Paternal Grandfather
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Food Allergies _____	
<input type="checkbox"/> Seizures/Epilepsy _____	<input type="checkbox"/> Migraine Headaches _____	
<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Stroke _____	
<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> High Cholesterol _____	
<input type="checkbox"/> Thyroid Disease _____	<input type="checkbox"/> Anemia _____	
<input type="checkbox"/> Tuberculosis _____	<input type="checkbox"/> Mental Retardation _____	
<input type="checkbox"/> Mental Illness _____	<input type="checkbox"/> Liver Disease _____	
<input type="checkbox"/> Crohn's Disease _____	<input type="checkbox"/> Ulcerative Colitis _____	
<input type="checkbox"/> Gastroesophageal Reflux Disease (GERD) _____		
<input type="checkbox"/> Gastritis _____	<input type="checkbox"/> Ulcer Disease _____	
<input type="checkbox"/> Irritable Bowel Syndrome _____	<input type="checkbox"/> Polyps _____	
<input type="checkbox"/> Hirschsprung's Disease _____	<input type="checkbox"/> Celiac Disease _____	
<input type="checkbox"/> Cystic Fibrosis _____	<input type="checkbox"/> Gallbladder Disease _____	

Patient Name _____

SOCIAL HISTORY:

Who resides with patient (list below):

Name

Relationship to Patient

_____	_____
_____	_____
_____	_____
_____	_____

Name of child's school or daycare: _____

Grade Level: _____

Are there any school problems regarding grades or peers? _____

Are there any stresses at home? Yes No If Yes, please explain. _____

Your previous medical records are important in providing us with a complete picture of your past medical history and current medical treatment. Did you bring them with you today? Yes No If not, please make arrangements to provide us with this information.

Filled out by: _____ Relationship: _____
(Please Print)

Signature: _____ Date: _____ Phone Number: _____

Clinician Signature: _____ Date: _____