

CHILD MEDICAL HISTORY QUESTIONNAIRE

Patient's Name: _____ Age: _____ Date: _____

Form Completed By: _____ Relationship to Patient (if not self): _____

Current Health Concerns:

What concerns would you like to address today? What are the main symptoms that are bothering your child?

Medical History:

Is your child being treated for any health problems? If yes, please list them below. Yes No

Birth history:

Any complications: Yes No

Full term: Yes No

If no, how many weeks gestation? _____

Birth weight: _____

Has your child ever had surgery? Yes No

If so, please list the type of surgery and date, starting with the most recent:

Allergies:

Any allergies or reactions to medications or substances? Please check all that apply N/A

Penicillin Levaquin

Sulfa "Mycins" (ex. Erythromycin)

Aspirin/Ibuprofen Codeine, Morphine

Tetracycline Cephalosporin

Other: _____

Reaction: _____

Other hospitalization (non-surgical)? Yes No

If yes, please list the reason and date, starting with the most recent:

Emergency room visits? Yes No

If yes, please list the reason and date, starting with the most recent:

Any problems with insect stings? Yes No

Never stung

Reaction: _____ Date: _____

Local swelling

Hives, swelling, itching over entire body

Has your child had allergy tests before? Yes No

At what age? _____

Which doctor and where? _____

To what was your child allergic? _____

Did he/she receive allergy shots? Yes No

How many days per week of school does your child miss due to health problems? _____

Medications: Please list all prescription and non-prescription medication, including vitamins and herbals, with name, strength, how often you take them, and when they were started:

Medication	Strength (mg/ #puffs)	How often	Since When

Immunizations: Up to date? Yes No

If no, why not? _____

Has your child ever had pneumonia vaccine? Yes No Date of last flu vaccine: _____

Family History: Please check if your child's parents, grandparents, aunts/uncles, siblings, or cousins have/had any of the following (indicate which family member):

<input type="checkbox"/> Hay fever:	<input type="checkbox"/> Gastrointestinal disease (reflux):
<input type="checkbox"/> Asthma:	<input type="checkbox"/> Diabetes:
<input type="checkbox"/> Eczema:	<input type="checkbox"/> Hypertension:
<input type="checkbox"/> Hives:	<input type="checkbox"/> Lung disease:
<input type="checkbox"/> Recurrent infections:	<input type="checkbox"/> Heart disease:
<input type="checkbox"/> Sinus troubles:	<input type="checkbox"/> Stroke:
<input type="checkbox"/> Food Allergy:	<input type="checkbox"/> Cancer:
<input type="checkbox"/> Other:	

Social History:

What grade is your child in, or is the child in daycare/preschool? _____
 How many days per week? _____

Is your child exposed to secondhand smoke? Yes No

If so, who smokes? _____

Diet:

Is your child eating solid foods? Yes No
 If yes, table food or baby jar foods? (please circle)

Milk/formula/breastfeeding? (please circle)
 If formula, what type? _____

Environmental History:

How long have you lived in your residence?

How old is the property? _____

Please circle all that apply:

Air conditioning: (central / wall unit / none)
 Humidifier/dehumidifier present? Yes No
 Flooring: (wood / tile / carpet / linoleum / rugs)
 Bedding: (mattress / box spring / waterbed / futon)
 Pillow: (feather / non-feather)

Pets? If yes, list types: _____
 Do they go into the bedroom? Yes No

Is there a basement? Yes No
 If yes, is there a history of flooding? Yes No
 Is there mold growing in your house? Yes No
 If yes, where? _____

Any problems with roaches or rodents? Yes No

Personal Health Review: Please check all that apply to you/your child:

General:

How do you rate your/your child's overall health?

- Excellent Very good Good
 Not very good Poor
 Weight gain/loss
 Fever or chills
 Night sweats

Comments/other: _____

Skin:

- Rashes or itching. Location: _____
 Hives or swelling
 Eczema. Location: _____

Comments/other: _____

Head:

- Headaches
 Recent head trauma

Comments/other: _____

Ears:

- Itching
 Fullness/popping
 Hearing problems
 Frequent ear infections

Comments/other: _____

Eyes:

- Itching/burning Swelling
 Tearing/discharge Eyelid irritation
 Redness Painful with light

Comments/other: _____

Nose/Sinuses:

- Itching/sneezing Frequent sinus infection
 Drainage. Color: _____
 Change in sense of smell
 Congestion Nasal polyps
 Mouth breathing Snoring

Have you ever had a CT scan of sinuses? Yes No

Do your symptoms occur all year long? Yes No

What season are they worse? _____

Throat:

- Itching/soreness Throat clearing
 Post nasal drip Thrush (yeast infection)
 Bad breath Change in voice

Comments/other: _____

Lungs/Chest:

- Cough Wheezing
 Shortness of breath Chest tightness
 Sputum production Bloody sputum

What triggers your breathing problems?

- Exercise Pollen Emotions
 Animal Colds Cold air
 Smoke/Odors Weather change
 Pregnancy Dust Other: _____

Do you wake up at night because of your breathing or cough? Yes No

If yes, how often? _____ times a (night/ week/ month)

Comments/other: _____

Gastrointestinal:

- Nausea/vomiting
 Diarrhea
 Heartburn/reflux
 Abdominal pain

Comments/other: _____

<p>Muscle and bone:</p> <p><input type="checkbox"/> Painful or swollen joints</p> <p><input type="checkbox"/> Stiffness <input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> Muscle weakness</p> <p>Comments/other: _____</p> <p>_____</p> <p>_____</p>	<p>Heart:</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Ankle swelling</p> <p><input type="checkbox"/> Heart palpitations</p> <p>Comments/other: _____</p> <p>_____</p> <p>_____</p>
<p>Nervous system and brain:</p> <p><input type="checkbox"/> Weakness/clumsiness</p> <p><input type="checkbox"/> Tingling/burning <input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Delayed development <input type="checkbox"/> Speech delay</p> <p>Comments/other: _____</p> <p>_____</p> <p>_____</p>	<p>Urinary tract:</p> <p><input type="checkbox"/> History of frequent bladder infections</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Trouble starting urine</p> <p><input type="checkbox"/> Loss of urine with cough or sneeze</p> <p>Comments/other: _____</p> <p>_____</p> <p>_____</p>
<p>Blood and metabolism:</p> <p><input type="checkbox"/> Easy bleeding/bruising</p> <p><input type="checkbox"/> Swollen lymph nodes</p> <p><input type="checkbox"/> History of thyroid disease</p> <p><input type="checkbox"/> History of diabetes</p> <p>Comments/other: _____</p> <p>_____</p> <p>_____</p>	<p>Reproduction:</p> <p>Planning on pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>History of yeast infections? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Comments/other: _____</p> <p>_____</p> <p>_____</p>
<p>Psychological:</p> <p><input type="checkbox"/> Anxiety <input type="checkbox"/> Difficulty sleeping</p> <p><input type="checkbox"/> Depression <input type="checkbox"/> Behavior problems</p> <p>Comments/other: _____</p> <p>_____</p> <p>_____</p>	<p>For staff only: Reviewed with patient and/or family.</p> <p>By _____ Date _____</p> <p>Initials _____ Date _____</p> <p>Initials _____ Date _____</p>