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| Pediatric HEALTH HISTORY QUESTIONNAIRE | | | | | | | | | | | | | | |
| All questions contained in this questionnaire are strictly confidential  and will become part of your medical record. | | | | | | | | | | | | | | |
| Name: | | |  | | |  | | DOB: |  | | | | | |
|  | | |  | | |  | |  | **Biological Sex**: 🞎 Male 🞎 Female | | | | | |
| GenderIdentity | | 🞎 Male 🞎 Female 🞎 Non-binary 🞎 Transgender 🞎 Prefer not to say 🞎 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
| Previous/referring provider: | | | |  | Date of last physical exam: | | | | |  | | | | |
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| PERSONAL HEALTH HISTORY | | | | | | | | | | | | | | |
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| Childhood illness: | | | 🞎 Measles 🞎 Mumps 🞎 Rubella 🞎 Chickenpox 🞎 Rheumatic Fever 🞎 Polio. 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| List any medical problems that other providers have diagnosed | | | | | | | | | | | | | | |
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| Surgeries | | | | | | | | | | | | | | |
| Year | Reason | | | | | | Hospital | | | | | | | |
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| Other hospitalizations | | | | | | | | | | | | | | |
| Year | Reason | | | | | | Hospital | | | | | | | |
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| Have your child ever had a blood transfusion? | | | | | | | | | | | 🞎 | Yes | 🞎 | No |

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| List your prescribed drugs, over the counter drugs, and vitamins/supplements | | | | | | | | | |
| Name the Drug | | | | Dose and Frequency Taken | | | Reason | | |
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| Allergies to medications/food/environment | | | | | | | | | |
| Allergen | | | | Reaction | | | | | |
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| FAMILY HEALTH HISTORY | | | | | | | | | |
|  | Age | | Significant Health Problems | |  | Age | | | Significant Health Problems |
| Father |  | |  | | Aunt/uncle *Maternal*  **Aunt/uncle**  *Paternal* | 🞎 M 🞎 F | |  |  |
| Mother |  | |  | | 🞎 M 🞎 F | |  |  |
| Sibling | 🞎 M 🞎 F |  |  | | 🞎 M 🞎 F | |  |  |
| 🞎 M 🞎 F |  |  | | 🞎 M 🞎 F | |  |  |
| 🞎 M 🞎 F |  |  | | Grandmother Maternal |  | | |  |
| 🞎 M 🞎 F |  |  | | Grandfather Maternal |  | | |  |
| 🞎 M 🞎 F |  |  | | Grandmother Paternal |  | | |  |
| 🞎 M 🞎 F |  |  | | Grandfather Paternal |  | | |  |
| **Other** | 🞎 M 🞎 F |  |  | | Other | 🞎 M 🞎 F | | |  |

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| **PREGNANCY AND BIRTH** |
| Is the child yours by: 🞎 birth 🞎 adoption 🞎 stepchild 🞎 other |
| Please indicate any medical problems during pregnancy: |
| Delivery by: 🞎 vaginal birth 🞎 cesarean If cesarean, please indicate reason: |
| Birthweight: \_\_\_\_\_\_\_ Birth length: \_\_\_\_\_\_\_ Was child breastfed? 🞎 no 🞎 yes If so, how long? \_\_\_\_\_\_\_ |
| Please indicate any concerns or health problems during the newborn period: |

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| Social history |  |
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| Birthplace: | Current Grade level: |
| Who lives at home? |  |
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| Are the child’s parents: 🞎 Married 🞎 Unmarried 🞎 Divorced 🞎 Separated |
| Childcare situation: 🞎 parents 🞎 others Please specify: |
| How many hours per night does your child sleep? \_\_\_\_\_\_ Does your child wake at night? 🞎 no 🞎 yes If so, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does your child take daytime naps? 🞎 yes 🞎 no |
| Do you have any concerns about your child’s sleeping habits? 🞎 yes 🞎 no |
| Does your child see a dentist regularly? 🞎 yes 🞎 no Does your child have any dental appliances? 🞎 yes 🞎 no |
| Has your child had an eye exam? 🞎 yes 🞎 no Does your child wear glasses/contacts? 🞎 yes 🞎 no |
| At which age did your child: Sit alone \_\_\_\_\_\_ Walk alone \_\_\_\_\_\_ Say words \_\_\_\_\_\_ Daytime toilet train \_\_\_\_\_\_  Girls only: Age at first menstrual period \_\_\_\_\_\_\_ |
| Is violence at home a concern? 🞎 yes 🞎 no |
| Are there guns in the home? 🞎 yes 🞎 no |
| Does your child have exposure to smoke? 🞎 yes 🞎 no |
| Does your child live in or visit a building built before 1978? 🞎 yes 🞎 no  Does your child live in or visit a building with ongoing repairs/remodeling? 🞎 yes 🞎 no  Does your child eat or chew on non-food things like paint chips or dirt? 🞎 yes 🞎 no  Does your child have a family member or friend who has or has had an elevated blood lead level? 🞎 yes 🞎 no  Is your child a newly arrived refugee or adoptee? 🞎 yes 🞎 no  Does your child come in contact with an adult whose job or hobby involves lead exposure? 🞎 yes 🞎 no  Does your family use products from other countries such as pottery, spices, health remedies, or food? 🞎 yes 🞎 no |
| Concerns about your child: 🞎 alcohol 🞎 tobacco/vaping 🞎 drugs 🞎 sexual activity 🞎 aggressive behavior  Other (please explain): |
| Please list any hobbies, sports, or other activities/interests that your child enjoys: |

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| Health concerns |
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| Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain. |

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| 🞎 | Skin | 🞎 | Chest/Heart | 🞎 | Recent changes in: |
| 🞎 | Head/Neck | 🞎 | Back | 🞎 | Weight |
| 🞎 | Ears | 🞎 | Intestinal | 🞎 | Energy level |
| 🞎 | Nose | 🞎 | Bladder | 🞎 | Ability to sleep |
| 🞎 | Throat | 🞎 | Bowel | 🞎 | Other pain/discomfort: |
| 🞎 | Social concerns | 🞎 | Mental health/depression/anxiety |  |  |
| 🞎 | Bedwetting | 🞎 | Developmental delays/concerns |

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| Please briefly explain above concerns: |