To be Completed by the Patient's Legal Guardian.

Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your child's medical record.

Patient Name *(Last, First, M.I.)*:	☐ **M** ☐ **F** **DOB:**
Person completing form:	**Relationship to patient:**
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Immunizations and dates:	☐ DTAP	☐ Pneumonia
	☐ Hepatitis A	☐ Hepatitis B
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*
	☐ Meningitis	☐ Chickenpox

Prenatal & Birth History

Length of pregnancy (Full Term is 40 weeks) ________________ Weeks

Complications:

Location of Birth:	Days in Hospital following birth:

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Has the patient ever had a blood transfusion?	☐ Yes	☐ No

List the patient's prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction Patient Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, bike riding)					
	☐ Occasional vigorous exercise (i.e., sport or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., sport or recreation 4x/week for 30 minutes)					
Diet	Is the patient on a special diet?				☐ Yes	☐ No
	If yes, is the patient on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals the patient eats in an average day?					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					

Family Life

Who lives in the patient's primary home?

Name	Age	Relationship to Patient

Does the patient have a second home? ☐ Yes ☐ No

How many days/month does the patient live in second home?

Who lives in the patient's second home?

Name	Age	Relationship to Patient

Does the patient or do any of the individuals the patient lives with have English as a second language?

Number of hours/week the patient spends:
In daycare _________ In School (Name of School) __________________________ Other: (Specify) ____________________________

How many hours/week is the patient home alone?

Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐	Yes	☐	No

FAMILY HEALTH HISTORY

					AGE	SIGNIFICANT HEALTH PROBLEMS
Siblings				**Mother**		
		AGE	Significant Health Problems	**Father**		
	☐ M ☐ F			**Grandmother** Maternal		
	☐ M ☐ F			**Grandfather** Maternal		
	☐ M ☐ F			**Grandmother** Paternal		
	☐ M ☐ F			**Grandfather** Paternal		

OTHER PROBLEMS

Check if the patient has, or had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

List any issues or questions you would like the doctor to address today