Personal Health History Questionnaire Cover Sheet

Name of patient _____

Date of birth _____ **Gender (circle): Female Male Other**

Contact Person _____ **Phone number** _____

Relationship to patient _____

This area for office use only – please proceed to next page

Date questionnaire returned to us: _____ **make sure shot record is attached**

Date approved by MD: _____

Date parent/guardian notified: _____ Date next well check is due _____

Insurance: _____

ID#: _____

Subscriber: _____

Subscriber birthdate: _____

Personal Health History Questionnaire

Name of patient _____ **Date of birth** _____
Person filling out questionnaire _____ **Relationship to patient** _____

Birth and Development History

Were there any problems during pregnancy? If yes, please explain. ❑No problems

Length of pregnancy: ❑full term ❑born early by _____ weeks ❑born late by _____ weeks
Type of delivery: ❑vaginal ❑C-section Birth weight: _____

Were there any problems during delivery or right after birth? If so, please explain. ❑No problems

Did baby have any problems which resulted in having to stay in the hospital? If yes, please explain. ❑No problems

Did baby have jaundice? ❑No problems
If yes, how was jaundice treated? (phototherapy, hospitalization, etc.)
How was baby mostly fed? ❑Breast ❑Formula ❑Both Were there any problems with feeding? If so, please explain.
❑No problems

Did your child have any delays in his/her growth or development (for example, poor weight gain, abnormally short, speech delay, delays in walking or other motor skills, etc.)? If yes, please explain. ❑No problems

Past Medical History

Allergies List any known medications, foods, or anything else (i.e. seasonal, animals, etc.) your child is allergic to and describe your child's reaction (i.e. hives, rash, breathing problems, etc.) ❑My child has no known allergies.

Medications List all medicines your child is currently taking or has taken regularly in the past year. Include prescription and over-the-counter medicines, vitamins, and herbal/natural remedies and list the dosage of each medicine. ❑No medications.

Well Checks/Physical Exams Has your child received regular check-ups (well checks or physical exams) since birth (every 2-3 months for first two years of life and every 1-2 years for 3 years and older)? If not, please explain why. ❑Yes, my child has had regular check-ups.

When was your child's last well check or physical exam?

Immunizations ❑**REQUIRED: I have attached my child's immunization record(s) with all immunizations and dates received.** List any problems or reactions your child has had to vaccines. ❑No problems

Hospitalizations Has your child ever been hospitalized overnight? If yes, list date and reason for hospitalization(s).
❑Never hospitalized

Surgeries Has your child ever had surgery? If yes, list date, type of surgery, and reason for surgery. ❑No surgeries

Injuries Has your child ever had an injury that required medical treatment (i.e. sprain, fracture, dislocation, concussion, burn, cut that required stitches or staples, etc.) If yes, indicate type and location of injury and date or age of child.
❑No injuries requiring medical treatment

Example: fractured R arm at age 5

Medical Problems Has your child had any medical problems that have been treated by a doctor? If yes, list type of problem, date or age of child when the problem occurred, and how the problem was treated. Especially indicate any recurring or unusual problems. ❑No problems

Example: Recurrent ear infections from age 1 to 4, treated with antibiotics and ear tubes

Example: Asthma diagnosed at age 3, takes albuterol inhaler about once a month and Singulair once a day, followed by specialist

Specialist Care and Referrals Has your child been followed by any specialist physicians or referred to a therapist (i.e. physical, occupational, or speech therapy) for treatment? If so, list specialist's name, type of specialty or type of therapy, and reason they are following your child.

Example: Dr. John Smith, Allergy-Pulmonology, for asthma and allergy shots. Example: Dr. Jane Smith, Cardiologist, for ASD heart defect

Example: Dr. Jack Smith, Dermatologist, for atopic dermatitis. Dr. Mary Smith, Neurology, for seizure disorder

Child's Medical History Questions

Indicate whether YOUR CHILD has had the following illnesses or medical conditions, either past or present.

Explain "yes" answers below. If you have described the medical problem on the previous page under "Medical Problems", you may write "see Medical Problems section."

Ear, Nose, Throat, Respiratory

Y or N Frequent ear infections
Y or N Frequent sinus infections
Y or N Swimmer's ear
Y or N Hearing loss
Y or N Sleep apnea
Y or N Frequent canker (mouth) sores
Y or N Frequent Strep throat
Y or N Bronchitis
Y or N Bronchiolitis or RSV infection
Y or N Pneumonia
Y or N Asthma
Y or N Wheezing
Y or N Chronic cough
Y or N Other ear, nose, throat or respiratory problems (describe)

Eye

Y or N Vision problems
Y or N Strabismus (eyes not aligned)
Y or N Other eye problems (describe)

Allergies

Y or N Seasonal allergies or hay fever
Y or N Anaphylaxis (severe allergic reaction)
Y or N Food allergy
Y or N Hives
Y or N Other allergy problems

Heart

Y or N High blood pressure
Y or N Heart murmur
Y or N Racing heart beat or skipping beats
Y or N Kawasaki disease
Y or N Heart defects or problems from birth
Y or N Fainting
Y or N Other heart problems (describe)

Nutrition and Hormones

Y or N Diabetes
Y or N Poor weight gain
Y or N Overweight
Y or N High cholesterol
Y or N Thyroid problems
Y or N Short stature
Y or N Early puberty (before 8 years)
Y or N Other nutrition or hormonal problems (describe)

Digestive

Y or N Frequent stomach aches
Y or N Recurrent constipation
Y or N Recurrent diarrhea
Y or N Heartburn or reflux disease
Y or N Hepatitis (specify type)
Y or N Hernia (specify location)
Y or N Jaundice
Y or N Lactose intolerance
Y or N Eating disorder (anorexia or bulimia)
Y or N Other digestive problems (describe)

Kidney, Bladder, Genitalia

Y or N Kidney problems
Y or N Recurrent urine/bladder infections
Y or N Blood in urine
Y or N Boys: hypospadius, undescended testicle
Y or N Girls: menstrual problems
Y or N Other kidney, bladder, or genitalia problems (describe)

Child's Medical History Questions, continued

Explain "yes" answers below. If you have already described the medical problem on the previous page under "Medical Problems", you may write "see Medical Problems section."

Blood

Y or N Anemia
Y or N Bleeding problems
Y or N Other blood problems (describe)

Neurology and Psychology

Y or N Concussion or other head injury
Y or N Recurrent or frequent headaches
Y or N Febrile seizures
Y or N Seizure disorder
Y or N ADD or ADHD
Y or N Anxiety problems
Y or N Panic attacks
Y or N Depression
Y or N Other neurology or psychological problems (describe)

Development and Learning

Y or N Developmental delay
Y or N Autism spectrum disorder
Y or N Learning disorder
Y or N Speech delay or speech problems
Y or N Other developmental or learning problems

Joints and Bones

Y or N Frequent joint pains
Y or N Scoliosis
Y or N Osgood-Schlatter
Y or N Other joint or bone problems (describe)

Skin

Y or N Atopic dermatitis (eczema)
Y or N Swollen glands
Y or N 2nd or 3rd degree burn
Y or N Other skin problems (describe)

Infections

Y or N Recurrent boils or skin infections
Y or N Infectious mononucleosis ("Mono")
Y or N MRSA (resistant Staph) infection
Y or N Chicken pox
Y or N Shingles (Herpes zoster)
Y or N Scarlet fever
Y or N Hemangioma (vascular birthmark)
Y or N Positive PPD (TB skin test)
Y or N Tuberculosis
Y or N Reaction to vaccines (shots)
Y or N Other recurrent or unusual infections

Other

Y or N Cancer (specify type)

Family History Questions Indicate whether any **first degree relatives** (mother, father, brother, sister) have had the following illnesses or medical conditions, either past or present.

Explain "yes" answers below, including who had the problem (mother, father, etc.).

Ear, Nose, Throat, Respiratory

Y or N Frequent ear infections
Y or N Hearing loss
Y or N Sleep apnea
Y or N Asthma
Y or N Wheezing
Y or N Chronic cough
Y or N Other ear, nose, throat or respiratory problems (describe)

Eye

Y or N Vision problems
Y or N Strabismus (eyes not aligned)
Y or N Other eye problems (describe)

Allergies

Y or N Seasonal allergies or hay fever
Y or N Anaphylaxis (severe allergic reaction)
Y or N Food allergy
Y or N Other allergy problems

Heart

Y or N High blood pressure
Y or N Heart murmur
Y or N Irregular heart rate
Y or N Heart attack before age 50
Y or N Heart defects or problems from birth
Y or N Other heart problems (describe)

Nutrition and Hormones

Y or N Diabetes
Y or N Overweight
Y or N High cholesterol or high triglycerides
Y or N Thyroid problems
Y or N Short stature
Y or N Early puberty (before 8 years)
Y or N Other nutrition or hormonal problems (describe)

Digestive

Y or N Eating disorder (anorexia or bulimia)
Y or N Heartburn or reflux disease
Y or N Hepatitis (specify type)
Y or N Hernia
Y or N Jaundice
Y or N Liver problems
Y or N Gallbladder problems
Y or N Inflammatory bowel disease (Crohn's, ulcerative colitis)
Y or N Other digestive problems (describe)

Kidney, Bladder, Genitalia

Y or N Kidney disease
Y or N Bladder or genitalia problems
Y or N Menstrual problems

Blood

Y or N Anemia
Y or N Bleeding problems
Y or N Other blood problems (describe)

Neurology and Psychology

Y or N Recurrent or frequent headaches
Y or N Febrile seizures
Y or N Seizure disorder
Y or N ADD or ADHD
Y or N Anxiety problems
Y or N Panic attacks
Y or N Depression
Y or N Other neurology or psychological problems (describe)

Family History Questions, continued

Explain "yes" answers below, including who had the problem (mother, father, etc.).

Development and Learning

Y or N Developmental delay
Y or N Autism spectrum disorder
Y or N Learning disorder
Y or N Speech delay or speech problems

Joints and Bones

Y or N Scoliosis
Y or N Other joint or bone problems (describe)

Skin

Y or N Atopic dermatitis (eczema)
Y or N Other skin problems (describe)

Infections

Y or N Recurrent boils or skin infections
Y or N MRSA (resistant Staph) infection
Y or N Positive PPD (TB skin test)
Y or N Tuberculosis
Y or N Other recurrent or unusual infections

Other

Y or N Cancer (specify type)
Y or N Sudden or unexplained death before age 50

Do any other diseases or illnesses run in your family, especially unusual or hereditary conditions?
❑No other diseases or illnesses run in the family to my knowledge.

I certify that, to the best of my knowledge, my answers to the above questions are complete and correct.
I understand that the doctors may request me to obtain copies of actual past medical records (for example, regarding ongoing medical problems) from previous physicians as needed to best care for my child's medical needs.

Signature of parent/guardian: **Date completed:**