Today's Date:	

INITIAL HEALTH HISTORY QUESTIONNAIRE

Birth to 12 years old

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

Name *(Last, First, M.I.)*:	☐ M ☐ F	Date of Birth:
Mother/Father/Guardian:		
Previous or referring doctor:		
Reason for visit:		

PERSONAL HEALTH HISTORY

List all medications and supplements taken regularly

Name the Drug or Supplement	Taken for:	Dose (strength and frequency)	Prescribed by: (write "Self" if self-prescribed)

Allergies to medications

Name the Drug	Reaction You Had

Childhood illness: ☐ Asthma ☐ Bronchitis ☐ Chickenpox ☐ Croup ☐ Ear Infections ☐ Eczema ☐ Frequent Colds
☐ Measles ☐ Mumps ☐ Rubella ☐ Rheumatic Fever ☐ Pneumonia ☐ Polio ☐ Scarlet Fever
☐ Strep Tonsillitis ☐ Other

Immunizations and dates:			
	☐ DTaP *Diptheria, Tetanus, Pertussis*	☐ Influenza	☐ Rotavirus
	☐ Hepatitis A	☐ MMR *Measles, Mumps, Rubella*	☐ Tetanus
	☐ Hepatitis B	☐ Pneumonia	☐ Chickenpox *(Varicella)*
	☐ HPV	☐ Polio	☐ Other:

Screening Exams: Please indicate the date of your child's last exam and whether it was normal.

Exam	Date	Result	Exam	Date	Result
Electroencephalogram			Hearing		
Psychological Evaluation			Speech Language		

Patient Name:______________________________________ DOB:________________

Hospitalizations		Surgeries	
Year	Reason	Year	Reason

List any medical problems that other doctors have diagnosed

FAMILY HEALTH HISTORY

Please place an "X" in the relevant boxes.

Condition:	Mother	Father	Sibling	Grandparent (maternal)	Grandparent (paternal)
Alcoholism					
Autoimmune					
Cancer (specify type)					
Diabetes					
Heart Disease					
High cholesterol					
Hypertension					
Mental Illness					
Migraine					
Multiple Sclerosis					
Osteoporosis					
Seizures					
Stroke					
Thyroid					

HEALTH HABITS AND PERSONAL SAFETY

Diet	Is your infant currently breastfeeding? ☐ Yes ☐ No	Was your child breastfed? ☐ Yes ☐ No If yes, for how long? If no, indicate type of formula (milk, soy):
	Age began: Solids foods______ Sitting______ Crawling______ Walking______ First words______	
	Does your child follow a special diet? ☐ Yes ☐ No	If yes, specify:
	Does your child avoid any foods? ☐ Yes ☐ No	If yes, specify:
	How much water does your child drink per day?	Is it filtered water? ☐ Yes ☐ No ☐ Sometimes
	Does your child drink cola/soda?	
	Please list the typical foods eaten for:	
	Breakfast:	
	Lunch:	
	Dinner:	
	Snacks:	
Exercise	☐ Sedentary (No exercise)	
	☐ Mild exercise (i.e. plays on playground, runs around house)	
	☐ Occasional vigorous exercise (i.e. rides bike, team sports)	
	☐ Regular vigorous exercise (i.e. team sports, swimming, most days of week)	

 Patient Name:____ DOB:________________

Sleep	Does your child have trouble falling asleep?	☐ Yes	☐ No
	Does your child wake during the night?	☐ Yes	☐ No
	If yes, does he/she have trouble falling back asleep?	☐ Yes	☐ No
	Does your child wake feeling rested?	☐ Yes	☐ No
	Average number of hours of sleep:		
Personal Safety	Does your child have vision or hearing loss?	☐ Yes	☐ No
	Is your child in a car seat or booster? ☐ Yes ☐ No — If not, does your child wear his/her seat belt?	☐ Yes	☐ No
	Does your child wear his/her helmet?	☐ Yes	☐ No
	Do you avoid excess UV exposure or wear sunscreen?	☐ Yes	☐ No
	Is the battery current in your smoke detector?	☐ Yes	☐ No
School Age Children	Has your child ever been "held back" or had to repeat a grade?	☐ Yes	☐ No
	Are you concerned about your child's attention span?	☐ Yes	☐ No
	Does your child like school?	☐ Yes	☐ No
	Any concerns about your child's behavior at school?	☐ Yes	☐ No
	Any concern about how he/she is doing academically?	☐ Yes	☐ No
Birth History	Mother's age at child's birth:		
	Mother's health during pregnancy: ☐ Bleeding ☐ Diabetes ☐ Hypertension ☐ Nausea ☐ Thyroid Problems ☐ Cigarettes, Alcohol, Drug use		
	Term: ☐ Full ☐ Premature ☐ Late — Length of Labor: — Child's weight at birth:		
	Type of birth: ☐ Vaginal ☐ Cesarean Section ☐ Forceps ☐ Vacuum ☐ Trauma?		
	Any newborn problems? ☐ Jaundice ☐ Hospitalization ☐ Other? Explain:		

MENTAL HEALTH		
Is stress a major problem for your child?	☐ Yes	☐ No
Does your child seem depressed?	☐ Yes	☐ No
Does your child panic when stressed?	☐ Yes	☐ No
Does your child have problems with eating or appetite?	☐ Yes	☐ No
Has your child intentionally harmed him/herself?	☐ Yes	☐ No
Is there a history of or concern of sexual or physical abuse or inappropriate touching?	☐ Yes	☐ No
Are you or your child currently seeing a counselor? ☐ Yes ☐ No If so, who?		

FEMALES ONLY			
Has your child begun her menstrual cycle? ☐ Yes ☐ No	Age at onset of menstruation:		
First day of last menstrual period: ______/______/________	Number of days of flow:		
Period every ______ days			
Heavy periods, irregularity, spotting, pain, or discharge?		☐ Yes	☐ No

 Patient Name:____ DOB:________________

Review of Systems: Mark "C" fo current problems; for problems in the past, please mark the YEAR it occurred.					
Current? Past? (Write Date)	Allergic/Immunologic	Current? Past? (Write Date)	Ears, Nose, Mouth, Throat (cont.)	Current? Past? (Write Date)	Hematological
	Food Allergies (please specify):		Epistaxis (nosebleeds)		Anemia
			Hoarseness		Bleeding Tendency
			Hypoglycemia		Bruise Easily
	Environmental allergies		Ringing in ear		Musculoskeletal
	Hay fever symptoms		Sinus problem		Back pain (chronic)
	Cardiovascular		Sore throat		Foot pain
	Chest pain		Eyes		Joint pain
	Irregular heartbeat		Blurred Vision		Leg pain
	Murmur (heart)		Loss of vision		Neck pain
	Palpitations		Pain or soreness in or about the eyes		Neurological
	Shortness of breath at rest		Photosensitivity		Difficulty concentrating
	Shortness of breath in the night		Gastrointestinal		Dizziness
	Shortness of breath with exercise		Abdominal pain		Headache
	Syncope (fainting)		Blood in stool		Numbness
	Dermatologic (Skin)		Constipation		Seizures
	Acne		Diarrhea		Tingling
	Cold sores		Excess gas		Tremors
	Eczema		Indigestion		Psychiatric
	Hives		Loss of appetite		Anxiety
	Pruritis (itching)		Melena (dark, tarry stools)		Depression
	Rash		Nausea		Insomnia
	Endocrine		Swallowing difficulty		Memory Loss
	Cold intolerance		Vomiting		Mood changes
	Dry Skin		Weight gain		Nightmares
	Excess hair growth		Weight loss, unintentional		Respiratory
	Extreme thirst		Yellowing of skin (jaundice)		Asthma
	Hair loss		Genitourinary		Cough
	Hyperglycemia		Blood in urine		Wheezing
	Thyroid disease		Painful urination		Shortness of breath
	Unusual fatigue		Urinary difficulty		Constitutional:
	Ears, Nose, Mouth, Throat		Urinary frequency		High fevers
	Bleeding gums		Urinary output low		Night sweats
	Cough, chronic		Urinating frequently at night		ADD/ADHD
	Difficulty with hearing				Other? Please explain:
	Ear infection				

Patient Name:______________________________________ DOB:________________