[redacted] Please print, fill in, and bring with you for your office visit

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:_____