HEALTH QUESTIONNAIRE

Patient's Name _____ Birth Date _____

Parent's Name _____ Parent's Name _____

Previous Medical Care _____

I. PERINATAL HISTORY (Mother)

1. Number of pregnancies _____

2. Number of miscarriages _____

3. Number of stillbirths _____

4. Number of living children _____

5. Number of premature infants _____

6. Age/cause of any child deaths _____

II. DURING PREGNANCY WITH THIS CHILD, DID YOU

1. Receive regular prenatal care? __ YES __ NO By whom? _____

2. Take any vitamins or iron? ? __ YES __ NO

3. Take any other medications or hormones? ? __ YES __ NO

4. Have high blood pressure or protein in the urine? ? __ YES __ NO

5. Have excessive vaginal bleeding or discharge? ? __ YES __ NO

6. Have any accidents or x-rays? ? __ YES __ NO

7. Deliver on time? __ YES __ NO

Number of weeks early _____ late _____

III. LABOR AND DELIVERY

1. Did membranes (bag of water) break more than 24 hours before delivery? __ YES __ NO

2. Was labor induced? ? __ YES __ NO If yes, why? _____

3. Was labor more than 24 hours? __ YES __ NO

4. Did you receive anesthesia? __ YES __ NO What type? _____

5. Was infant born head first? __ YES __ NO

6. Did you have a Caesarean section? __ YES __ NO Why? _____

IV. NEONATAL

1. Birth weight _____ Length _____

2. Did infant breathe and cry immediately at birth? __ YES __ NO

3. Did the infant have any of the following problems?

a. Difficult or rapid respirations? __ YES __ NO
b. Cyanosis (blue? __ YES __ NO
c. Jaundice (yellow? __ YES __ NO
d. Convulsions or unconscious spells? __ YES __ NO
e. Hemorrhage? __ YES __ NO
f. Infection? __ YES __ NO
g. Diarrhea? __ YES __ NO
h. Skin eruption? __ YES __ NO
i. Deformities? __ YES __ NO
j. Other _____ __ YES __ NO

4. Was the infant breast fed? __ YES __ NO How long? _____

5. Did infant leave the hospital with you? __ YES __ NO

6. Place of birth _____

Hospital _____

Doctor _____

7. Is the child adopted? __ YES __ NO

V. DIET

1. Was infant a problem eater? Or colicky? __ YES __ NO

2. What is a typical daily diet?

Breakfast _____

Lunch _____

Dinner _____

3. Vitamins? __ YES __ NO Type _____

4. Does your child have a good appetite? __ YES __ NO

5. Has there been a recent large weight loss or weight gain? __ YES __ NO

VI. CHILD DEVELOPMENT

1. When did your child:

a. Smile _____ mos d. Sit alone _____ mos

b. Roll over _____ mos e. Walk _____ mos

c. Crawl _____ mos f. Talk _____ mos

2. Is child toilet trained? __ YES __ NO

3. Does child wet the bed? __ YES __ NO

4. Any behavior or school problems that concern you? __ YES __ NO

5. Does your child get along with other children? __ YES __ NO

VII. IMMUNIZATIONS – Please attach copy of immunization record.

VIII. PAST MEDICAL HISTORY

1. Any serious or chronic medical problems in the past? __ YES __ NO

What? _____

2. Chicken pox, age _____ __ YES __ NO

3. Surgery/Operations? __ YES __ NO When? _____

4. Fractures/Accidents? __ YES __ NO

5. Hospitalizations? ? __ YES __ NO

Where? _____ When? _____

Why? _____

6. Does child take any medications regularly (except vitamins) ? __ YES __ NO

What? _____

7. Does child have any allergies? __ YES __ NO

To what? _____

8. Drug allergies? ? __ YES __ NO

To what? _____

9. Allergy (hyposensitization) shots? __ YES __ NO

10. Received blood transfusion? __ YES __ NO

11. Does you child have a habit of eating dirt, paper, clay, or other non-food substance? __ YES __ NO

IX. FAMILY HISTORY

1. Age of Father _____ Mother _____

Age of other children: Sisters _____

Brothers _____

2. Are there any diseases in the family? __ YES __ NO

What? _____

3. Has anyone in either the mother's or the father's family had: (circle disease) __ YES __ NO

diabetes tuberculosis allergies heart disease anemia blood problems

tumors / cancers kidney disease visual / hearing problems

4. Have any blood relatives had a myocardial infarct (heart attack) prior to age 50? __ YES __ NO

5. Are all of the family members living together at home? __ YES __ NO

X. REVIEW OF SYSTEMS – Does your child:

Skin

1. Have persistent or recurrent skin rash? __ YES __ NO

HEENT

1. Complain frequently of headaches? __ YES __ NO

2. Seem to see and hear normally? __ YES __ NO

3. Wear glasses? __ YES __ NO

4. Ever look "cross-eyed" ? __ YES __ NO

5. Have frequent ear infections? __ YES __ NO

Number per year? _____

6. Have frequent colds or sore throats? __ YES __ NO

Number per year? _____

7. Had previous bouts of hoarseness of "croup"? __ YES __ NO

8. See the dentist at least once a year? __ YES __ NO

9. Brush teeth daily? __ YES __ NO

Respiratory

1. Breathe noisily? Or through mouth constantly? __ YES __ NO

2. Chronic cough? __ YES __ NO

3. Complain of chest pain? Shortness of breath? __ YES __ NO

4. Had wheezing or asthma? __ YES __ NO

5. Had pneumonia? __ YES __ NO

6. Does anyone living in your household smoke? ? __ YES __ NO

Cardiac

1. Any known heart trouble or heart murmurs? __ YES __ NO

Hematologic

1. Bruise easily or bleed excessively from minor cuts? __ YES __ NO

2. Had frequent or persistent nose bleeds? __ YES __ NO

3. Ever been anemic? __ YES __ NO

4. Is your child easily fatigued or pale? __ YES __ NO

Gastrointestinal

1. Recurrent stomach aches, diarrhea, or constipation? __ YES __ NO

2. Ever had blood in stools (or tarry black stools? __ YES __ NO

3. Have greasy or excessively foul smelling stools? __ YES __ NO

Genital - Urinary

1. Any kidney or bladder problems? Infections? __ YES __ NO

2. Any burning or irritations with urination? __ YES __ NO

3. Ever had blood in urine? __ YES __ NO

4. Males: Are both testicles present? __ YES __ NO

Females: Menstruate? __ YES __ NO Age started? _____

Have vaginal discharge? __ YES __ NO

Musculo - Skeletal

1. Ever had any painful of swollen bones or joints? __ YES __ NO

2. Have any weak muscles or paralysis? __ YES __ NO

3. Are you concerned about crooked feet or legs? __ YES __ NO

Neuro Development

1. Ever had a seizure or convulsion? __ YES __ NO

2. Any episodes of loss of consciousness? __ YES __ NO

3. Any difficulty walking or running? __ YES __ NO

4. Are you concerned with any of the following problems?

a. Stuttering or other speech problems? __ YES __ NO

b. Bad temper/temper tantrums? __ YES __ NO

c. Breath holding? __ YES __ NO

d. Nail biting/thumb sucking? __ YES __ NO

` e. Soils pants? __ YES __ NO

f. Trouble toilet training? __ YES __ NO

g. Trouble sleeping? __ YES __ NO S

XI. SAFETY

1. Are old medications disposed of? __ YES __ NO

2. Are medications locked up at home? __ YES __ NO

3. Are dangerous products in both the home and garage out of child's reach? __ YES __ NO

4. Did your child wear a seatbelt or ride in a car seat the last time you drove? __ YES __ NO

5. Does your house have a smoke alarm? __ YES __ NO

Is the battery periodically checked? __ YES __ NO

6. Is there a gun in your house? __ YES __ NO

Is it locked up and unloaded? __ YES __ NO

7. Does your child wear a bike helmet? __ YES __ NO

8. Are you concerned about lead in your home? __ YES __ NO

Signature _____ Date _____

We thank you for your time and co-operation in completing this questionnaire. We feel that it will allow us to better know and care for your child.