Pediatric & Adolescent Care

Health questionnaire for children age 2 and over

Dear Parent:

By filling out this questionnaire, you give us a more complete record of your child. It also provides a permanent history we can refer to later. Answer any question you can. Don't worry about those you skip. We will discuss with you any items that either you or we believe should be explained more fully.

Full name of child: _____

Previous Pediatrician: _____ City & State: _____

Does your child have any serious or chronic medical problems? No _____ Yes _____

Please explain: _____

Do you have any concerns about developmental problems? No _____ Yes _____

Please explain: _____

Family History: Have any close relatives had problems with the following:

	Relationship to this child (maternal/paternal parent, grandparent, aunt, uncle)
Deafness	_____
Allergies	_____
Asthma	_____
Tuberculosis	_____
Heart disease (prior to age 50)	_____
High blood pressure (prior to age 50)	_____
High cholesterol	_____
Anemia/Bleeding disorders	_____
Liver disease	_____
Kidney disease	_____
Diabetes (prior to age 50)	_____
Epilepsy or convulsions	_____
Alcohol abuse	_____
Drug abuse	_____

Mental illness _____

Mental retardation _____

Immune problems, immune deficiency

(childhood cancer, HIV, AIDS, etc.) _____

Additional pertinent conditions _____

Child's Past Medical History:

Surgeries No _____ Yes _____ Dates: _____

Hospitalizations No _____ Yes _____ Dates: _____

Serious injuries or accident No _____ Yes _____ explain: _____

Learning or behavior problem No _____ Yes _____ explain: _____

Convulsions or other neurologic problems No _____ Yes _____ explain: _____

Severe/recurrent headaches No _____ Yes _____

Use of alcohol or drugs No _____ Yes _____

Problems with vision/eyes No _____ Yes _____ explain: _____

Anemia or bleeding problem No _____ Yes _____

Frequent ear infections No _____ Yes _____

Problems with ears or hearing No _____ Yes _____

Lung problems No _____ Yes _____

Heart problems or heart murmur No _____ Yes _____

Frequent abdominal pain/constipation No _____ Yes _____

Urinary tract infections No _____ Yes _____

If female, have menstrual periods started? No _____ Yes _____ age of onset? _____

If female, any problems with periods No _____ Yes _____

Bone/joint problems No _____ Yes _____

Chronic or recurrent skin problems (acne, eczema, etc.) No _____ Yes _____

Thyroid or other endocrine problems No _____ Yes _____

Diabetes No _____ Yes _____

Chickenpox No _____ Yes _____ if yes, when? _____

Mother's name: _____ DOB: _____
Living & in good health? No _____ Yes _____

Father's name: _____ DOB: _____
Living & in good health? No _____ Yes _____

List ages, sex and general health of this child's brothers & sisters:

Name: _____ Age _____ Sex _____ Health ok _____ Not ok _____

Illnesses: _____

Name: _____ Age _____ Sex _____ Health ok _____ Not ok _____

Illnesses: _____

Name: _____ Age _____ Sex _____ Health ok _____ Not ok _____

Illnesses: _____