



Pediatric Health Questionnaire
6 – 12 years

Please complete and return

Successful health care and preventative medicine are only possible when the doctor has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible; it will help your child to get the most from their visits. Mark anything that you do not understand with a question mark. Thank you.

Name: _____ Date of first visit: _____

Age: _____ Date of Birth: ____/____/____ Gender: Female / Male

Mother's name: _____ Father's name: _____

Parent's relationship status: Married Separated Divorced Widowed Single Partnership

Address: _____

City: _____ State: _____ Zip Code: _____

Contact parent: _____

Phone # (home): (____) _____ Parent's # (work): (____) _____ (cell): _____

May we leave confidential voice-mail messages for you at any of the above numbers? No / Yes (specify): Home / Work / Cell

Parent's e-mail address: _____

May we leave confidential E-mail messages for you at the above address? No / Yes

____ (initials) I understand that it is possible if my child's personal health information is sent over email that it may be viewed by others. I recognize and accept this possibility and authorize my doctor to communicate facets of my child's personal health information with me over email.

How did you hear about our clinic? _____

HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health concerns? List as many as you can in order of importance:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____



Does your child have a contagious disease at this time? Y N
 If yes, what? _____

Previous Illnesses

_____ Chicken pox	_____ Scarlet fever	Tonsillitis, approx. no. _____
_____ Measles	_____ Pneumonia	Ear infections, no. _____
_____ Mumps	_____ Frequent colds	Other (please list) _____
_____ Rubella	_____ Rheumatic fever	

Has your child had any of the following tests?	<u>When</u>	<u>Where</u>	<u>Results</u>
Electroencephalogram (EEG)			
Psychological evaluation			
Hearing tests			
Speech/Language tests			

Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

Immunizations

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Influenza	Y N
Other _____			

Any adverse reactions? Y N If yes, what ? _____

Allergies

Is your child hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental? _____

Breast fed? _____ how long? _____ Formula? _____ milk / soy _____

Family History

Member	Age	Important diseases	Living?	Cause of death
Mother				
Father				
Siblings				
Siblings				
*MGM				
*MGF				



*PGM				
*PGF				

M = Maternal (Mother) P = Paternal (Father) GM = Grandmother GF = Grandfather

Any other relevant family history? _____

What is your child's ethnic background? _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking. Please include dosage:

- 1) _____ 5) _____
- 2) _____ 6) _____
- 3) _____ 7) _____
- 4) _____ 8) _____

REVIEW OF SYSTEMS

Y = a condition now P = significant problem in the past N = never had

MENTAL/ EMOTIONAL

Mood Swings	Y	P	N	Anxiety/nervousness	Y	P	N
Irritability	Y	P	N	Cries easily	Y	P	N
Hyperactivity	Y	P	N	Unusual fears	Y	P	N
Introvert/extrovert	Y	P	N	Sleep problems	Y	P	N
Motion/car sickness	Y	P	N	Nightmares	Y	P	N

ENDOCRINE

Heat/cold intolerance	Y	P	N	Fatigue	Y	P	N
Excessive thirst	Y	P	N	Excessive hunger	Y	P	N



Low blood sugar

Y P N

High blood sugar

Y P N

Y = a condition now P = significant problem in the past N = never had

SKIN

Rashes	Y P N	Eczema, Hives	Y P N
Acne, Boils	Y P N	Itching	Y P N

HEAD

Headaches	Y P N	Head Injury	Y P N
Dizzy spells	Y P N	High fevers	Y P N

EYES

Glasses or contacts	Y P N	Tearing or dryness	Y P N
Eye pain/strain	Y P N		

EARS

Earaches	Y P N	Impaired hearing	Y P N
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NOSE AND SINUSES

Frequent colds	Y P N	Nose Bleeds	Y P N
Stuffiness	Y P N	Hayfever	Y P N
Sinus problems	Y P N	Loss of smell	Y P N

MOUTH AND THROAT

Frequent sore throat	Y P N	Canker sores	Y P N
Breath odor	Y P N		

RESPIRATORY

Cough	Y P N	Wheezing	Y P N
Asthma	Y P N	Bronchitis	Y P N

CARDIOVASCULAR

Heart disease	Y P N	Murmurs	Y P N
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URINARY

Frequent urination	Y P N	Bed wetting	Y P N
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GASTROINTESTINAL

Belching/passing gas	Y P N	Stomach aches	Y P N
Constipation	Y P N	Diarrhea	Y P N
Bowel Movements	How often _____		



Y = a condition now **P** = significant problem in the past **N** = never had

MUSCULOSKELETAL

Joint pain/stiffness	Y	P	N	Muscle spasms/cramps	Y	P	N
Broken bones	Y	P	N				

BLOOD/PERIPHERAL VASCULAR

Anemia	Y	P	N	Easy bleeding/bruising	Y	P	N
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Is there any information about your child's health that you would like to add?

What expectations do you have for your child from working with our clinic?

Done. Thank you for your time and effort. We look forward to helping your child in any way we can.