

**HEALTH QUESTIONNAIRE**

Patient's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Father's Name \_\_\_\_\_  
 Mother'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? .....           | NO  | YES |
| 4. Have high blood pressure or protein in the urine? ..... | NO  | YES |
| 5. Have excessive vaginal bleeding or discharge? .....     | NO  | YES |
| 6. Have any accidents or x-rays? .....                     | NO  | YES |
| 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? ..... | NO  | YES |
| 2. Was labor induced? .....   | NO  | YES |
| If yes, why? _____  |     |     |
| 3. Was labor more than 24 hours? .....  | NO  | YES |
| 4. Did you receive anesthesia? .....  | NO  | YES |
| What type? _____  |     |     |
| 5. Was infant born head first? .....  | YES | NO  |
| 6. Did you have a Caesarean section? .....                                      | NO  | YES |
| 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? .....                 | NO  | YES |
| b. Cyanosis (blue)? .....                                 | NO  | YES |
| c. Jaundice (yellow)? .....                               | NO  | YES |
| d. Convulsions or unconscious spells? .....               | NO  | YES |
| e. Hemorrhage? .....                                      | NO  | YES |
| f. Infection? .....                                       | NO  | YES |
| g. Diarrhea? .....  | NO  | YES |
| h. Skin eruption? .....                                   | NO  | YES |
| i. Deformities? _____                                     | NO  | YES |
| j. Other _____  | NO  | YES |
| 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? ..... NO YES
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? ..... NO YES

**VI. CHILD DEVELOPMENT**

1. When did your child:  
 a. Smile \_\_\_\_\_ mos  
 b. Roll over \_\_\_\_\_ mos  
 c. Crawl \_\_\_\_\_ mos  
 d. Sit alone \_\_\_\_\_ mos  
 e. Walk \_\_\_\_\_ mos  
 f. Talk \_\_\_\_\_ mos
2. Is child toilet trained? ..... YES NO
3. Does child wet the bed? ..... NO YES
4. Any behavior or school problems that concern you? ..... NO YES
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? ..... NO YES  
 What? \_\_\_\_\_
2. Chicken pox, age \_\_\_\_\_ NO YES
3. Surgery/Operations? ..... NO YES  
 When? \_\_\_\_\_
4. Fractures/Accidents? ..... NO YES
5. Hospitalizations? ..... NO YES  
 Where? \_\_\_\_\_ When? \_\_\_\_\_  
 Why? \_\_\_\_\_
6. Does child take any medications regularly (except vitamins)? ..... NO YES  
 What? \_\_\_\_\_
7. Does child have any allergies? ..... NO YES  
 To what? \_\_\_\_\_
8. Drug allergies? ..... NO YES  
 To what? \_\_\_\_\_
9. Allergy (hyposensitization) shots? ..... NO YES
10. Received blood transfusion? ..... NO YES
11. Does you child have a habit of eating dirt, paper, clay, or other non-food substance? ..... NO YES

**IX. FAMILY HISTORY**

1. Age of Father \_\_\_\_\_ Mother \_\_\_\_\_  
 Age of other children: Sisters \_\_\_\_\_  
 Brothers \_\_\_\_\_
2. Are there any diseases in the family? ..... NO YES  
 What? \_\_\_\_\_

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

**HEENT**

- |   |     |     |
|---|-----|-----|
| 1. Complain frequently of headaches? . . . . .            | NO  | YES |
| 2. Seem to see and hear normally? . . . . .               | YES | NO  |
| 3. Wear glasses? . . . . .                                | NO  | YES |
| 4. Ever look "cross-eyed"? . . . . .                      | NO  | YES |
| 5. Have frequent ear infections? . . . . .                | NO  | YES |
| Number per year? _____                                    |     |     |
| 6. Have frequent colds or sore throats? . . . . .         | NO  | YES |
| Number per year? _____                                    |     |     |
| 7. Had previous bouts of hoarseness of "croup"? . . . . . | NO  | YES |
| 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? . . . . . | NO | YES |
| 2. Chronic cough? . . . . .                                | NO | YES |
| 3. Complain of chest pain? Shortness of breath? . . . . .  | NO | YES |
| 4. Had wheezing or asthma? . . . . .                       | NO | YES |
| 5. Had pneumonia? . . . . .                                | NO | YES |
| 6. Does anyone living in your household smoke? . . . . .   | NO | YES |

**Cardiac**

- |  |    |     |
|--|----|-----|
| 1. Any known heart trouble or heart murmurs? . . . . . | NO | YES |
|--|----|-----|

**Hematologic**

- |  |    |     |
|--|----|-----|
| 1. Bruise easily or bleed excessively from minor cuts? . . . . . | NO | YES |
| 2. Had frequent or persistent nose bleeds? . . . . .             | NO | YES |
| 3. Ever been anemic? . . . . .                                   | NO | YES |
| 4. Is your child easily fatigued or pale? . . . . .              | NO | YES |

**Gastrointestinal**

- |  |    |     |
|--|----|-----|
| 1. Recurrent stomach aches, diarrhea, or constipation? . . . . . | NO | YES |
| 2. Ever had blood in stools (or tarry black stools)? . . . . .   | NO | YES |
| 3. Have greasy or excessively foul smelling stools? . . . . .    | NO | YES |

**Genital - Urinary**

- |  |     |     |
|--|-----|-----|
| 1. Any kidney or bladder problems? Infections? . . . . . | NO  | YES |
| 2. Any burning or irritations with urination? . . . . .  | NO  | YES |
| 3. Ever had blood in urine? . . . . .                    | NO  | YES |
| 4. Males: Are both testicles present? . . . . .          | YES | NO  |
| Females: Menstruate? . . . . .                           | YES | NO  |
| Age started? _____                                       |     |     |
| Have vaginal discharge? . . . . .                        | NO  | YES |

**Musculo - Skeletal**

- |   |    |     |
|---|----|-----|
| 1. Ever had any painful or swollen bones or joints? ..... | NO | YES |
| 2. Have any weak muscles or paralysis? .....              | NO | YES |
| 3. Are you concerned about crooked feet or legs? .....    | NO | YES |

**Neuro Development**

- |  |    |     |
|--|----|-----|
| 1. Ever had a seizure or convulsion? .....               | NO | YES |
| 2. Any episodes of loss of consciousness? .....          | NO | YES |
| 3. Any difficulty walking or running? .....              | NO | YES |
| 4. Are you concerned with any of the following problems? |    |     |
| a. Stuttering or other speech problems? .....            | NO | YES |
| b. Bad temper/temper tantrums? .....                     | NO | YES |
| c. Breath holding? .....                                 | NO | YES |
| d. Nail biting/thumb sucking? .....                      | NO | YES |
| e. Soils pants? .....                                    | NO | YES |
| f. Trouble toilet training? .....                        | NO | YES |
| g. Trouble sleeping? .....                               | NO | YES |

**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? .....   | NO  | YES |
| 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? .....                                    | NO  | YES |

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.

Sincerely,

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