PATIENT HEALTH HISTORY QUESTIONNAIRE

DATE:____

Mother's Name:_________________________Age:____________
Occupation:____
Father's Name:__________________________Age_____________
Occupation:____

Patient's Name:__________________
Date of Birth:___________________

A. PREGNANCY AND BIRTH

1. Mother's age at birth _____________
2. Did mother have any illness during pregnancy? YES NO
3. Did she take any medications other than vitamins? YES NO
4. Was the baby on time? YES NO
5. What was the birthweight? _____________
6. Did the baby have any trouble starting to breathe? YES NO

B. FAMILY HISTORY

1. Are the child's parents both in good health? YES NO
2. Circle any diseases that this child's parents, grandparents, brothers sisters, or aunts and uncles have had: anemia, asthma, allergies, diabetes high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS, other____.
3. List age, sex and general health of brothers and sisters:

____
____

4. Have any of your children died? YES NO

C. FEEDING AND NUTRITION

1. Is your child's appetite usually good? YES NO
2. Was there severe colic or any unusual feeding problems during the first 3 months? YES NO
3. Is your child breast or bottle fed? _____________
4. If breast fed, how long was the child breast fed? _____________
5. If using formula, which brand? _____________
6. Does he/she take vitamins? YES NO

D. SAFETY AND ENVIROMENT

1. Do you live in a private house, apartment, or mobile home? YES NO
2. Do you know the hottest temp. of water in your pipes? YES NO
3. Are there working smoke alarms on each floor of your house? YES NO
4. Does your child always use a car seat/seat belt? YES NO
5. Are there any smokers in the household? YES NO
6. Does your child always wear a helmet when riding a bicycle? YES NO

E. PAST MEDICAL HISTORY

1. Where has your child gone for check-up until now? ________________
2. Date of last check-up? ________________
3. Has your child had reactions to any immunizations? YES NO
   Which ones?____________________________________
4. Has your child had allergic reactions to any medications foods, or insect bites? YES NO
   Which ones?_____________________________________
5. Any hospitalizations other than birth? YES NO
   For what?_______________________________________
6. Any serious injuries?______________________________ YES NO
7. Are any medications taken regularly? YES NO
   Which ones?_______________________________________

F. DEVELOPMENT AND BEHAVIOR

1. At what age did your child sit alone? ______________
2. At what age did he/she walk alone? ______________
3. Did he/she say any words by the time he/she was 1 1/2 years old? YES NO
4. How does this child compare to other children his/her age? ______________
5. What grade is your child in? ______________
6. Has he/she had any trouble in school? ______________
7. Does he/she get along with other kids? YES NO
8. Circle if your child has had any of the following: nail biting, thumb sucking, bed wetting, problems with toilet training, bad temper, hyperactivity, nightmares, speech problems, discipline problems, other.

G. REVIEW OF SYSTEMS

Does Your Child Have A History Of Any Of The Following:

1. Frequent ear infections- 6 or > per year YES NO
2. Eye problems? YES NO
3. Teeth Problems? YES NO
4. Frequent colds or sore throat? YES NO
5. Pneumonia, asthma or cough? YES NO
6. Frequent urination? YES NO
7. Heart murmur or heart problems? YES NO
8. Diarrhea or constipation? YES NO
9. Convulsions or other problems with the nervous system? YES NO
10. Eczema, hives or other skin conditions? YES NO
11. Has your child ever been anemic? YES NO
12. Please list any other medical problems______________
____

H. Do you have a record of your child's immunizations? YES NO

I. If adults in the household work outside of the home, what child care arrangements are made for this child?
____
Day Care Phone Number:______________________