PEDIATRIC HEALTH HISTORY QUESTIONAIRE

IDENTIFICATION INFORMATION

Date ___________________

Patient's Name______________________ Male___ Female___ D.O.B._______ Age____ Yrs.____ Mos. ___
Parent or Guardian's Name ____
Address ____ Telephone ___________________

REASON FOR VISIT

1. Comprehensive periodic examination Yes _____ No _____
2. Medical problem (s): Please list. About when did they begin? What concerns you most?

____
____
____

PLEASE CHECK THE APPROPRIATE BOX

EYES

1. Crossed or wandering eyes? .... ___ No ___ Yes
2. Vision changes past year? .... ___ No ___ Yes
3. Wear glasses or contact lenses? ..... ___ No ___ Yes
4. Eye muscle surgery? .... ___ No ___ Yes
5. Trouble reading or watching TV? ..... ___ No ___ Yes

EARS

6. Repeated infections? .... ___ No ___ Yes
7. Chronic drainage? .... ___ No ___ Yes
8. Ear tubes? .... ___ No ___ Yes
9. Speech problems or speech delay? ___ No ___ Yes
10. Deafness or decreased hearing? ..... ___ No ___ Yes

NOSE AND THROAT

11. Trouble breathing through the nose? ... ___ No ___ Yes
12. Frequent colds? .... ___ No ___ Yes
13. Nose allergy symptoms? Itchy nose? .. ___ No ___ Yes
14. Nose bleeds? .... ___ No ___ Yes
15. Frequent sore or strep throat infections? . ___ No ___ Yes
16. Still have tonsils? .... ___ No ___ Yes

TEETH

17. Decay or defects? .... ___ No ___ Yes
18. Bite (occulusion) defects? .... ___ No ___ Yes
19. Date of last visit to dentist? .... _____________
    To Orthodontist?______________________________

SKIN

20. Birthmarks or moles? .... ___ No ___ Yes
21. Acne? .... ___ No ___ Yes
22. Heavy tan or often sunburned? .... ___ No ___ Yes

CHEST

23. Chronic cough? .... ___ No ___ Yes
24. Short of breath with activity? .... ___ No ___ Yes
25. Wheezing with exercise? .... ___ No ___ Yes
26. Asthma/hay fever? .... ___ No ___ Yes
27. Pneumonia? .... ___ No ___ Yes
28. Tuberculosis skin test change? .... ___ No ___ Yes

HEART

29. Heart murmur? .... ___ No ___ Yes
30. Heart beats too fast? .... ___ No ___ Yes
31. Palpitations or irregular heart beat? ___ No ___ Yes
32. Pain over the heart? .... ___ No ___ Yes
33. Chest or shoulder pain
    with activity? .... ___ No ___ Yes
34. High blood pressure? .... ___ No ___ Yes
35. Blood cholesterol test done? .... ___ No ___ Yes

BLOOD

36. Anemia? .... ___ No ___ Yes
37. Bleeding or easy bruising problems? . ___ No ___ Yes
38. Clotting problems? (Hemophilia?) ... ___ No ___ Yes

DIGESTIVE TRACT

39. Chronic or frequent diarrhea? .... ___ No ___ Yes
40. Constipation? .... ___ No ___ Yes
41. Recurrent vomiting? .... ___ No ___ Yes
42. Recurrent abdominal pain? .... ___ No ___ Yes
43. Bloody bowel movements? .... ___ No ___ Yes
44. Jaundice or yellow skin? .... ___ No ___ Yes
45. Prolonged loss of appetite? .... ___ No ___ Yes
46. Overeating followed by vomiting? ... ___ No ___ Yes

URINARY TRACT

47. Bed wetting problems? .... ___ No ___ Yes
48. Infection one or more times? .... ___ No ___ Yes
49. Bloody or dark colored urine? .... ___ No ___ Yes
50. Difficulty starting or stopping the stream? ___ No ___ Yes
51. Painful or frequent urination? .... ___ No ___ Yes

MUSCULO-SKELETAL

52. Limb or growing pains? .... ___ No ___ Yes
53. Painful or swollen joints? .... ___ No ___ Yes
54. Problems with muscle coordination
    or strength? .... ___ No ___ Yes
55. Posture problems? .... ___ No ___ Yes
56. Foot or ankle problems? .... ___ No ___ Yes
57. Severe back pain? .... ___ No ___ Yes
58. Scoliosis/abnormal curve of back? . ___ No ___ Yes
59. Lump or swelling of any bone? .... ___ No ___ Yes

NEUROLOGICAL
60. Headaches? ___ No ___ Yes
61. Any fatigue or listlessness? ___ No ___ Yes
62. Any dizziness? ___ No ___ Yes
63. Any loss of balance? ___ No ___ Yes
64. Convulsion, seizure, or fit? ___ No ___ Yes
65. Difficulty controlling use of hands, arms, or legs? ___ No ___ Yes

GENERAL
66. Recent weight loss? ___ No ___ Yes
67. Too short? Too tall? ___ No ___ Yes
68. Too fat? Too thin? ___ No ___ Yes
69. Easy tiring or fatigability? ___ No ___ Yes
70. Heavy or excessive appetite? ___ No ___ Yes
71. Trouble sleeping? ___ No ___ Yes

CHILDHOOD DISEASES
72. Whooping cough? ___ No ___ Yes
73. Chicken pox? ___ No ___ Yes
74. Measles? ___ No ___ Yes
75. Rubella (3-day measles)? ___ No ___ Yes
76. Mumps ___ No ___ Yes
77. Polio? ___ No ___ Yes
78. Kawasaki Disease? ___ No ___ Yes

PUBERTY
BOYS ONLY Approx. Age_____
79. Voice change? _____ Yrs.
80. Muscular growth? _____ Yrs.
81. Axillary hair present? _____ Yrs.
82. Pubic hair present? _____ Yrs.
83. Testes growing? _____ Yrs.
84. Penis growing? _____ Yrs.
85. Swollen painful breast (s) _____ Yrs.
86. Interest in girls? _____ Yrs.

PUBERTY
GIRLS ONLY Approx. Age_____
87. Breasts developing? _____ Yrs.
88. Menstrual period present? _____ Yrs.
89. Age & date of first menstrual period? _____ Yrs.
90. Regular periods? ___ No ___ Yes
91. Pain or discomfort with period? ___ No ___ Yes
92. Heavy flow? ___ No ___ Yes
Scant flow? ___ No ___ Yes
93. Use? Tampons _ Pads

FAMILY MEDICAL HISTORY Please write in the relationship of the mother's or father's relatives (such as children, brothers, sisters, grandparents, aunts or uncles) who have had any of the conditions listed. Include conditions that baby's mother and father have had.

(X)	CONDITIONS	RELATIONSHIP	MAT (✓)	PAT (✓)	(X)	CONDITIONS	RELATIONSHIP	MAT (✓)	PAT (✓)
	Birth Defects					Metabolic Disease/Thyroid Problem			
	Chromosomal Abnormality (Genetics Disease)					Alcoholism (Genetics Disease)			
	Obesity/Overweight					Diabetes			
	DES Exposure					Muscular Dystrophy			
	Congenital Hearing Loss					Eye Disease/Glaucoma			
	Mental Retardation/Nervous Disorders					Cystic Fibrosis/Lung Disease			
	Migraine Headaches					Tuberculosis			
	Food Allergies					Anemia/Blood Disorders			
	Hay Fever					Bleeders/Hemophilia			
	Asthma/Emphysema					Convulsive Disease (Epilepsy)			
	High Blood Pressure					Hepatitis/Gall Bladder Disease			
	Heart/Valve trouble					Peptic Ulcer/Colitis/Irritable Bowel			
	Coronary Artery Disease (Note age at Death))					Venereal Disease			
	Stroke					Kidney Problems (1) Infections			
	Rheumatoid Arthritis/Gout					(2) Malformations			
	Rheumatic Fever					AIDS/ARC/HIV POSITIVE			
	Cancer or Malignancy								