PATIENT HISTORY QUESTIONNAIRE

(Please fill out **all that applies**.)

Child Name: _____ Date of Birth: _____

Race: Black White Asian Native/Alask PacIsle Other/Multi Ethnicity: Hispanic Non-Hispanic

Pregnancy History (Mother's, of and before this patient):

Mother's age at time of delivery: _____

	Circle		Explain
Any miscarriages, stillbirths or Abortions:	No	Yes	_____
Problems, illnesses or injury:	No	Yes	_____
Medications:	No	Yes	_____
Smoked cigarettes:	No	Yes	_____
Alcohol or drugs use:	No	Yes	_____
Other:	No	Yes	_____

Baby Delivery:

Delivered at (Hospital name) : _____

Delivery Type: Vaginal_____ Caesarean section_____

Gestation age: Full Term_____ Pre-Term_____ (if so) At how many weeks:_____

Birth weight: _____lbs. _____oz.

Baby stayed at hospital _____ days.

Did your baby have any trouble starting to breath?	No	Yes	_____
Did your baby have trouble while in hospital?	No	Yes	_____

Child's Development:

Sat at: _____ months

Walked at: _____ months

First word at: _____ months

Bladder trained at: _____ months

Bowel trained at: _____ months

Current grade in school: _____

School performance rating: GOOD ____ FAIR ____ POOR ____

Childhood Diseases:	Circle		Please Explain
Has your child had chickenpox?	No	Yes	_____
Has your child had any serious accidents?	No	Yes	_____
Has your child had broken bones?	No	Yes	_____
Has your child had removal of adenoids or tonsils?	No	Yes	_____
Has your child had any other surgeries?	No	Yes	_____

Does you child have:

Ear problems?	No	Yes	_____
Stomach aches?	No	Yes	_____
Constipation?	No	Yes	_____
Convulsions or Seizures?	No	Yes	_____
Bladder or Kidney infections?	No	Yes	_____

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Skin troubles?	No	Yes	_____
Allergies?	No	Yes	_____
Wheezing or asthma?	No	Yes	_____
Snoring or difficulty breathing at night?	No	Yes	_____
Eye problems?	No	Yes	_____
Bedwetting?	No	Yes	_____
Behavior problems?	No	Yes	_____
School problems?	No	Yes	_____
Any chronic illness?	No	Yes	_____
Does your child take any medicines regularly?	No	Yes	_____
Is your child taking fluoride?	No	Yes	_____

Where has your child received previous medical care?
Doctor / Clinic name: _____
City/State: _____

Any inherited illnesses in the family? No Yes _____

Do any relatives have:	Circle		Who? In relation to patient
Allergies?	No	Yes	_____
Heart attack before age 55 years?	No	Yes	_____
Thyroid disease?	No	Yes	_____
Tuberculosis?	No	Yes	_____
Kidney disease?	No	Yes	_____
Mental illness?	No	Yes	_____
Convulsions/seizures/epilepsy?	No	Yes	_____
Diabetes?	No	Yes	_____
Cancer?	No	Yes	_____
Alcoholism?	No	Yes	_____
Drug abuse problems?	No	Yes	_____
Anyone affected by domestic violence?	No	Yes	_____

Number of Adults live at home:_____
Number of children at home: _____
List all (adults and children):

Name	Relationship to Patient	Age	Health Issues
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Residence:

House_____ Apartment_____ Age of building / house: _____