



Patient name: _____ Patient DoB: _____

Parent/guardian name(s): _____

Parent/guardian Signature: _____

Patient Health History Questionnaire (Ages 5-11) Today's date: _____

Medications/supplements (include name and dosage): _____

Allergies to medications/food (include reaction): _____

Surgical/hospitalization history (include month/year): _____

Family History (specify relation for each)

- Asthma _____
- Attention deficit disorder _____
- Blood disorder _____
- Cancer (which type) _____
- Diabetes _____
- Heart disease before 55 _____
- High cholesterol _____
- Hypertension _____
- Kidney disease _____
- Mental illness/depression _____
- Sudden cardiac death _____
- Other: _____

Social History

Grade/School: _____ Pediatrician (if not with Arete): _____

Parents relationship status: _____ Vaccines up to date? Yes No

Names/ages of siblings: _____ Any household members smoke? Yes No

Others in the home: _____ Sports: _____

Other interests: _____

Medical History Diagnosed by a Healthcare Provider

- Allergies
- Anxiety/depression
- Arthritis
- Asthma
- Attention deficit disorder
- Autism
- Birth defects
- Broken bones
- Cancer (type) _____
- Other: _____
- Congenital heart disease/surgery
- Diabetes
- Ear infections (frequent)
- Gait problems
- GI problems
- Head injury
- Headaches
- High cholesterol
- Hypertension
- Pneumonia
- Reading problems/dyslexia
- Reflux disease (GERD)
- Seizures
- Skin issues
- Urinary tract infections
- Vision problems