



Date Revised: 05/08/09

CHILD'S HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.): _____ Gender: M F DOB: _____

Allergies:

No Allergies

Allergies to Medications None Please list. _____

Allergies to Food None Please list. _____ Symptoms: _____

Environmental Allergies None Please list. _____ Symptoms: _____

Seasonal Allergies None Please list. _____ Symptoms: _____

Skin Problems : None Eczema Dryness Acne

Stomach or Bowel Problems: None Stomach Aches Constipation Diarrhea (stool accidents or smearing)

Urinary Tract Problems: None Bedwetting Frequent Infections Daytime wetting

Any chronic illnesses/diseases which require frequent office visits or specialty care (excluding psychiatric)?

List any repeated or frequent physical complaints:

Has child been seen by a healthcare provider for any medical issue in the last 3 months?

Has child ever lived outside of the U.S.? Yes No If yes, has child had tuberculosis skin testing/chest x-ray? If yes, what were the results of tests/treatments?

Any sleep problems? Yes No If yes, please describe:

Any other medical information you wish to share?
