

**PEDIATRIC PATIENT
HISTORY QUESTIONNAIRE (0-12 YRS)**



Name(first/middle/last): _____ Date: _____

Date of Birth: (day) / (month) / (year) Age: _____ Gender: Female _____ Male _____

Mother's Name: _____ Father's Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone # (home): _____ Parent's # (work): _____

BC Care Card #: _____ Parent's E-mail Address: _____

How did you hear about our clinic? _____

HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health problems? List as many as you can in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Does your child have a contagious disease at this time? Y N

If yes, what? _____

PREVIOUS ILLNESSES

| | | | |
|-----------------|-------|----------------|-------|
| Tonsillitis | Y N | German measles | Y N |
| →approx. number | _____ | Chicken pox | Y N |
| Ear infections | Y N | Measles | Y N |
| →approx. number | _____ | Other | Y N |
| Rheumatic fever | Y N | →list | _____ |

| | | |
|--|-------------|--------------|
| Has your child had any of the following tests? | <u>When</u> | <u>Where</u> |
| Electroencephalogram (EEG) | _____ | _____ |
| Psychological evaluation | _____ | _____ |
| Hearing tests | _____ | _____ |
| Speech / language tests | _____ | _____ |

HOSPITALIZATIONS / SURGERIES / INJURIES

What hospitalizations, surgeries, or injuries has your child had?

IMMUNIZATIONS

| | | | |
|-----------------------|-----|-----------------------|-------|
| Polio | Y N | Pertussis | Y N |
| Tetanus shot | Y N | Diphtheria | Y N |
| Measles/Mumps/Rubella | Y N | Any adverse reactions | Y N |
| Influenza | Y N | → If yes, what? | _____ |

ALLERGIES

Is your child hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental? _____

Breast Fed? _____ How long? _____ Formula? _____ Milk/Soy _____

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Please list **any** prescription medications, over the counter medications, vitamins, or other supplements your child is taking:

- | | |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

REVIEW OF SYSTEMS

Y = A condition you have now

N = Never had

P = Significant problem in the past

Mental / Emotional

| | | | |
|-----------------------|-------|-----------------------|-------|
| Mood swings | Y P N | Anxiety / nervousness | Y P N |
| Irritability | Y P N | Cries easily | Y P N |
| Hyperactivity | Y P N | Unusual fears | Y P N |
| Introvert / extrovert | Y P N | Sleep problems | Y P N |
| Motion / car sickness | Y P N | Nightmares | Y P N |

Endocrine

| | | | |
|-------------------------|-------|------------------|-------|
| Head / cold intolerance | Y P N | Fatigue | Y P N |
| Excessive thirst | Y P N | Excessive hunger | Y P N |
| Low blood sugar | Y P N | High blood sugar | Y P N |

Skin

| | | | |
|-------------|-------|---------------|-------|
| Rashes | Y P N | Eczema, Hives | Y P N |
| Acne, Boils | Y P N | Itching | Y P N |

Head

| | | | |
|--------------|-------|-------------|-------|
| Headaches | Y P N | Head injury | Y P N |
| Dizzy spells | Y P N | High fevers | Y P N |

Eyes

| | | | |
|---------------------|-------|--------------------|-------|
| Glasses or contacts | Y P N | Tearing or dryness | Y P N |
| Eye pain / strain | Y P N | | |

Ears

| | | | |
|----------|-------|------------------|-------|
| Earaches | Y P N | Impaired hearing | Y P N |
|----------|-------|------------------|-------|

Nose and Sinuses

| | | | |
|----------------|-------|---------------|-------|
| Frequent colds | Y P N | Nose bleeds | Y P N |
| Stuffiness | Y P N | Hayfever | Y P N |
| Sinus problem | Y P N | Loss of smell | Y P N |

Mouth and Throat

| | | | |
|----------------------|-------|--------------|-------|
| Frequent sore throat | Y P N | Canker sores | Y P N |
| Breath odor | Y P N | | |

Respiratory

| | | | |
|--------|-------|------------|-------|
| Cough | Y P N | Wheezing | Y P N |
| Asthma | Y P N | Bronchitis | Y P N |

Cardiovascular

| | | | |
|---------------|-------|---------|-------|
| Heart disease | Y P N | Murmurs | Y P N |
|---------------|-------|---------|-------|

| | | | |
|--------------------|-------|----------------|-------|
| | | <u>Urinary</u> | |
| Frequent urination | Y P N | Bed wetting | Y P N |

| | | | |
|------------------------|------------|-------------------------|-------|
| | | <u>Gastrointestinal</u> | |
| Belching / passing gas | Y P N | Stomach aches | Y P N |
| Constipation | Y P N | Diarrhea | Y P N |
| Bowel movements | How often: | _____ | |

| | | | |
|------------------------|-------|------------------------|-------|
| | | <u>Musculoskeletal</u> | |
| Joint pain / stiffness | Y P N | Muscle spasms / cramps | Y P N |
| Broken bones | Y P N | | |

| | | | |
|--------|-------|------------------------------------|-------|
| | | <u>Blood / Peripheral Vascular</u> | |
| Anemia | Y P N | Easy bleeding / bruising | Y P N |

Is there any information about your child's health that you would like to add?

What expectations do you have for your child from working with our clinic?

Welcome! We're honored to be of service to you and your child!