

PATIENT HISTORY QUESTIONNAIRE



Please complete **both sides** of the form for **each** patient cared for at this clinic.

Patient's Name: _____ Date of birth: _____

Male Female

Clinic Use Only:
If medication allergy, place allergy sticker here

MEDICATION ALLERGIES

Does the patient have any medication allergies? Yes No

MEDICATION	REACTION	AGE DIAGNOSED
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

BIRTH HISTORY

Was the patient adopted? Yes No

Birth weight _____

Was the patient born At term Early Late

If early, how many weeks gestation? _____

Was the delivery Vaginal Cesarean

If Cesarean, why? Breech Other, please explain _____

Did the patient have any problems immediately after birth?
 Yes No If yes, explain _____

Did the patient's mother have any illnesses during pregnancy?
 Yes No Explain _____

During the pregnancy, did the patient's mother:
Smoke Yes No
Take any medications Yes No
Use drugs or alcohol Yes No

What _____
When _____

Did the patient's mother have any post-partum depression? Yes No

SURGICAL HISTORY

Has the patient had any surgeries or procedures? Yes No

DESCRIPTION OF SURGERY OR PROCEDURE	AGE AT TIME OF SURGERY
_____	_____
_____	_____
_____	_____
_____	_____

HOSPITALIZATION HISTORY

Has the patient been hospitalized over night (other than for the surgeries listed above)? Yes No

REASON FOR HOSPITALIZATION	AGE AT HOSPITALIZATION
_____	_____
_____	_____
_____	_____
_____	_____

Patient's Name: _____

Date of Birth: _____

PAST MEDICAL HISTORY

Does the patient have, or has he/she ever had the following:

If yes, please explain what age diagnosed, and specific details about the type of condition.

Food allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Environmental or nasal allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Chicken pox (illness, not vaccine)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Serious injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Eye or vision problem, or blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hearing problem or deafness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Asthma, wheezing, or nebulizer treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Heart problem, heart defect, heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Autoimmune disorder (lupus, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bleeding or clotting disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bladder or kidney problem (infection, reflux, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Constipation requiring medical treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cystic fibrosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Eating disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Genetic abnormality (Down Syndrome, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Immune problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
HIV or AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Liver problem or hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Stomach or intestinal problems (reflux, GERD, ulcers, Crohn's, ulcerative colitis, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Celiac disease or sprue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Menstrual or gynecologic problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Musculoskeletal disorders (scoliosis, osteoporosis, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Skin problem (eczema, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Seizure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Diabetes - insulin dependent (Type I)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Diabetes - non-insulin dependent (Type II)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Thyroid or other endocrine problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Problem with use of alcohol or drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Psychiatric or emotional problem (depression, anxiety, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Autism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Learning problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
ADD or ADHD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Behavior problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Mental retardation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Other _____			_____
Other _____			_____

Form completed by (print): _____

Relation to patient: _____

Signature: _____

Date: _____

We greatly appreciate your completing this form. It will help us to better care for your child.