PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

HIGH LAKES Health Care

Patient Name: _____ **Patient DOB:** _____

Both Parents / Guardian Names: _____

PERSONAL HISTORY

Birth Weight: ____ Pounds ____ Ounces	Prenatal or Birth Complications: ☐ Yes (Describe: _____) ☐ No	
Asthma: ☐ Yes ☐ No	Fainting: ☐ Yes ☐ No	Frequent Illnesses: ☐ Yes (Describe: _____) ☐ No
Hospitalizations (Date & Cause):		
Surgeries (Date & Type):		
Date of Last Menstrual Period (if applicable):	Other Health Problems:	

FAMILY HISTORY

	Onset Age / Comments	*Significant Health Problems*				
Father	____ /	☐ Diabetes ☐ Migraines	☐ Asthma ☐ Allergies	☐ Depression / Mental Illness ☐ Blood Clotting Disorder	☐ Cardiovascular Disease ☐ Thyroid Problems	☐ Hypertension ☐ Cancer
Mother	____ /	☐ Diabetes ☐ Migraines	☐ Asthma ☐ Allergies	☐ Depression / Mental Illness ☐ Blood Clotting Disorder	☐ Cardiovascular Disease ☐ Thyroid Problems	☐ Hypertension ☐ Cancer
Grandparents	____ /	☐ Diabetes ☐ Migraines	☐ Asthma ☐ Allergies	☐ Depression / Mental Illness ☐ Blood Clotting Disorder	☐ Cardiovascular Disease ☐ Thyroid Problems	☐ Hypertension ☐ Cancer
Siblings	____ /	☐ Diabetes ☐ Migraines	☐ Asthma ☐ Allergies	☐ Depression / Mental Illness ☐ Blood Clotting Disorder	☐ Cardiovascular Disease ☐ Thyroid Problems	☐ Hypertension ☐ Cancer

SOCIAL HISTORY

Live With: ☐ Mother ☐ Father ☐ Blended Family ☐ Self ☐ Other: _____ ☐ Brothers Age(s): _____ ☐ Sisters Age(s): _____			
Attend Daycare: ☐ Yes ☐ No	School Grade: _____	Smoking at Home: ☐ Yes ☐ No	Smoke: ☐ Yes ☐ No
Amount of TV Watched Daily: _____ Hours		Amount of Computer / Video Games Daily: _____ Hours	
Helmet Used While Cycling / Motorcycling: ☐ Yes ☐ No		Car Seat Used: ☐ Yes ☐ No	Seatbelt Used: ☐ Yes ☐ No
Guns Kept In Home: ☐ Yes ☐ No	If Yes, Are Guns Locked Up: ☐ Yes ☐ No		History of Traumatic Event: ☐ Yes ☐ No
Recreational Drug Use: ☐ Yes ☐ No	Alcohol Use: ☐ Yes ☐ No	Sexually Active: ☐ Yes ☐ No	Fluoride Use: ☐ Yes ☐ No
Dietary Concerns: ☐ Yes ☐ No	If Yes, Please Describe: _____		

REVIEW OF SYSTEMS (*Please Check All Symptoms Which Are Recurring Chronic Conditions – Explain Below*)

SYSTEMATIC
- ☐ Fever
- ☐ Chills
- ☐ Headache
- ☐ Stiff Neck
- ☐ Swollen Glands

EYES
- ☐ Vision Change
- ☐ Corrective Lenses
- ☐ Cataracts
- ☐ Eye Pain

SKIN
- ☐ Rash
- ☐ Persistent Itch

NERVOUS SYSTEM
- ☐ Dizziness
- ☐ Tremors
- ☐ Headaches
- ☐ Numbness
- ☐ Seizures

ENDOCRINE
- ☐ Excessive Thirst
- ☐ Weight Loss / Gain
- ☐ Menstrual Problems

ALLERGIC
- ☐ Hay Fever
- ☐ Medications
- ☐ Others: _____

_____

_____

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea / Vomiting
- ☐ Problems Eating

CARDIOVASCULAR
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Coughing

EARS, NOSE, THROAT
- ☐ Sore Throat
- ☐ Runny Nose
- ☐ Ear Pain

MUSCULOSKELETAL
- ☐ Joint Pain
- ☐ Deformities
- ☐ History of Fractures
- ☐ History of Trauma

GENITOURINARY
- ☐ Painful Urination
- ☐ Problems With Urination
- ☐ Vaginal Discharge

PSYCHOLOGICAL
- ☐ Low Mood
- ☐ Hyperactive
- ☐ Behavior Problem
- ☐ Considered Suicide
- ☐ Developmental Delay

- ☐ Other: _____
- ☐ Other: _____

Please explain:

I certify that all the information is correct to the best of my knowledge. I will not hold my doctor or any staff members responsible for any errors or omissions I may have made in the completion of this form.

Patient / Guardian Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____