Confidential Health Questionnaire

Child's Name: ____________________________ Birthdate __________

Name of person completing this form: ___________________________

Relationship to Child:________________Today's Date: ____________

1) *Who lives at home with child?* (Check all that apply)

☐ Mother ☐ Father ☐ Step parent ☐ Guardian ☐ Grandparent ☐ Siblings ☐ Pets(type)________________

2) *Is your child adopted?* ☐ No ☐ Yes If yes, age at the time of adoption: _____________

3) *Primary language spoken at home:*______________________ **4) *Ethnicity:*** _____________________

5) *Does your child attend?* Day care : ☐ No ☐ Yes Preschool: ☐ No ☐ Yes Days per week:_____

School: ☐ No ☐ Yes Grade:__________Name of school:_________________Performance:_______________

6) *Does your child participate in any activities outside of school?* ☐ No ☐ Yes ___________________________

7) *Is your child taking any?*

Medications: ☐ No ☐ Yes (please list)

____

____

____

Vitamins: ☐ No ☐ Yes

Supplements: ☐ No ☐ Yes

8) *Does your child have any allergies:*

Medications: ☐ No ☐ Yes (please list)

____

Foods: ☐ No ☐ Yes (please list)

____

Environment: ☐ No ☐ Yes (please list)

(dust, pollen, grass, cats, dogs, bees, etc)

____

9) *When riding in a car, how is your child restrained?*

☐ Rear facing car seat ☐ Forward facing car seat ☐ Booster seat ☐ Regular seat belt ☐ None

10) *Does anyone smoke at home?* ☐ No ☐ Yes If yes: ☐ Indoor or ☐ Outdoors only

11) *Is there a pool or spa in the home?* ☐ No ☐ Yes If yes, is there a perimeter fence and gate? ☐ No ☐Yes

12) *To assess for lead risk, was your home built prior to 1973?* ☐ No ☐Yes

13) *Are there firearms in the home?* ☐ No ☐ Yes

If yes, how are they stored? ☐ with ammunition ☐ without ammunition

14) *Are there any social stressors or family problems going on right now?*

____

____

15) *Are there any specific concerns that you wish to discuss at this visit today?*

____

____

____

Patient name____ Date of Birth _____________

16) How was the pregnancy and delivery of this child?

☐ Uncomplicated ☐ Complicated by ____

☐ Vaginal Delivery ☐ Cesarean Section (Indication:_______________________) Breech? ☐ No ☐ Yes

☐ Early (Prior to 37 weeks) How many weeks _____ ☐ On Time (37-42 weeks) ☐ Late (after 42 weeks)

Child's weight at birth_______lbs_________oz. Hospital of birth: _________________________________

17) What type of milk do/did you give your child in the first year?

☐ Breast milk - Until_____months of age ☐ Formula - which one? ______________________________

18) Did your child have any problems during the first months of life?

☐ Feeding problems/reflux ☐ Constipation ☐ Allergies ☐ Jaundice

19) Do you have any concerns about your child's development? ☐ No ☐ Yes (check all that apply)

☐ Speech ☐ Strength/gross motor skills ☐ Coordination/fine motor skills ☐ Socialization ☐ Problem Solving

20) Has your child ever received any developmental therapies, or special services? ☐ No ☐ Yes (check all that apply)

☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy ☐ Behavioral Therapy

21) Has your child ever been hospitalized or had surgery? ☐ No ☐ Yes (If yes, please provide details)

Date	Hospital	City and State	Reason	Length of Stay

22) Does your child have any previous, or ongoing problems or concerns? ☐ No ☐ Yes (check all that apply)

☐ Skin problems ☐ Eczema
☐ Asthma ☐ Allergic Rhinitis/hay fever
☐ Diabetes ☐ Serious Injury
☐ Heart murmur ☐ Many ear infections
☐ Many colds ☐ Many sore throats
☐ Hearing problems ☐ Vision problems
☐ Stomach Problems ☐ Constipation
☐ Diarrhea ☐ Kidney/bladder problems
☐ Hernia ☐ Hip/leg/foot problems
☐ Seizures ☐ Bed Wetting
☐ Behavior problems ☐ Sleep problems
☐ School problems ☐ Anemia
☐ Other________________________________
☐ Other ________________________________

23) Have any members of the family had any of the following conditions? If so, Who?

☐ No ☐ Yes Anemia ____________________
☐ No ☐ Yes Asthma ____________________
☐ No ☐ Yes Hay Fever __________________
☐ No ☐ Yes Migraines __________________
☐ No ☐ Yes Seizures ___________________
☐ No ☐ Yes Diabetes ___________________
☐ No ☐ Yes ADHD _____________________
☐ No ☐ Yes Mental Delay _______________
☐ No ☐ Yes Depression/Anxiety ___________
☐ No ☐ Yes Birth Defects _______________
☐ No ☐ Yes High Blood Pressure __________
☐ No ☐ Yes High Cholesterol ____________
☐ No ☐ Yes Other Heart Disease __________
☐ No ☐ Yes Thyroid Disease _____________