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.	Symptoms:
☐ 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?