Huntington Health Physicians

PEDIATRIC HEALTH ASSESSMENT QUESTIONNAIRE

Patient Name: _____ Today's Date:____/_____/_____

Date of Birth: _____/_____/_____ Age:_____ Gender: Male ☐ Female ☐

Person Completing Form:_____

Reason for your visit today

Birth History	
Any problems during pregnancy? ☐Y ☐N	If yes, specify:_____
Birth Hospital:_____	Birth Weight:_____ Length:_____
Delivery: ☐Vaginal ☐ C-Section	Delivery complications:_____
Term: ☐Premature (___weeks premature) ☐ Full Term	NICU: ☐ Yes ☐ No
Feeding: ☐Breast Fed ☐Formula Fed	

Allergies or Intolerances to Medication or Food

List medications or foods causing an allergic reaction below (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	***Reaction***	***Medication / Food***	***Reaction***

Medications and Vitamins

Prescribed drugs and over-the-counter drugs, such as vitamins or inhalers ☐ Check if using other sheet for medications

Medication	***Dosage***	***Frequency***	***Reason for use***

Past Medical History

Problem	**Date**

Surgeries & Hospitalization

Hospitalized for any surgical operation or serious illness

Date	***Reason***	***Hospital/Physician's Name***	***City, State***

Immunizations/Infectious Disease	
Please bring your child's immunization records to your appointment.	
Has your child had:	☐Chickenpox ☐Measles ☐ Mumps ☐ Rubella ☐ Meningitis ☐ Tuberculosis (TB)

Family Health History

Please check all that apply			**Patient's Mother**	**Patient's Father**	**Patient's Sibling**	**Relative** *Please write in*
Anemia	☐		☐	☐	☐	
Allergies	☐		☐	☐	☐	
Asthma	☐		☐	☐	☐	
Bleeding disorder	☐		☐	☐	☐	
Cancer	☐	Type:_____	☐	☐	☐	
Crohn's disease	☐		☐	☐	☐	
Diabetes	☐		☐	☐	☐	
Eczema	☐		☐	☐	☐	
Emotional problems	☐		☐	☐	☐	
Epilepsy	☐		☐	☐	☐	
Heart Attack	☐		☐	☐	☐	
High blood pressure	☐		☐	☐	☐	
High cholesterol	☐		☐	☐	☐	
Kidney Disease	☐		☐	☐	☐	
Lazy Eye	☐		☐	☐	☐	
Psoriasis	☐		☐	☐	☐	
Stroke	☐		☐	☐	☐	
Substance Abuse/Addiction	☐		☐	☐	☐	
Thyroid disease	☐		☐	☐	☐	
Tuberculosis	☐		☐	☐	☐	
Ulcerative Colitis	☐		☐	☐	☐	
Unexplained/Sudden Death	☐		☐	☐	☐	
Urinary Reflux	☐		☐	☐	☐	
Other	☐		☐	☐	☐	

Are there any other medical problems that run in your family? _____

Social History

Parents: ☐Married ☐Divorced ☐Separated ☐Single

List all people who live at home with the patient:

Name: _____ Age: _____ Relations to Patient: _____ Occupation: _____
Name: _____ Age: _____ Relations to Patient: _____ Occupation: _____
Name: _____ Age: _____ Relations to Patient: _____ Occupation: _____
Name: _____ Age: _____ Relations to Patient: _____ Occupation: _____
Name: _____ Age: _____ Relations to Patient: _____ Occupation: _____
Name: _____ Age: _____ Relations to Patient: _____ Occupation: _____

Is your child currently enrolled in daycare or school? Yes ☐ No ☐

Does your child participate in regular exercise? Yes ☐ No ☐ Explain:_____

Check if present at home: ☐ Firearm ☐Pool/Spa ☐Exposure to Smoke

Thank You for taking the time to complete this form!