CHILD/ADOLESCENT HEALTH QUESTIONNAIRE

Name: _____ Age:_____ Date:_____

BIRTH HISTORY:

Hospital where born:_____

Birth Weight:_____ Full term or premature? _____

Method of delivery: Vaginal_____ Cesarean section_____

During pregnancy did mother smoke cigarettes, marijuana, drink alcohol or take any medications?

If Yes, please explain: _____

Any problems or health concerns during pregnancy? YES NO

If yes, please explain:_____

Any issues as a newborn? YES NO

If yes, please explain:_____

EARLY DEVELOPMENT:

Feeding history: Breast milk? _____ Until what age?_____ Formula name?_____

Age solids started?_____ Sat?_____ Walked?_____ First words?_____

MEDICAL PROBLEMS:

Any problems after birth?	YES	NO
Any reactions to vaccinations?	YES	NO
Reactions to drugs?	YES	NO
Recurring infections?	YES	NO
Multiple (>3) ear infections by age 2?	YES	NO
Bronchitis or pneumonia?	YES	NO
Kidney or bladder infections?	YES	NO

History of seizures?	YES	NO
Constipation or recurrent diarrhea?	YES	NO
Hay fever? Asthma? Eczema?	YES	NO
Allergies to foods?	YES	NO
Childhood diseases? (e.g. chickenpox?)	YES	NO

<u>BEHAVIOR PROBLEMS:</u>

Please circle all that apply:

Temper tantrums Sleep problems Toilet training problems Aggression

Any other concerns? _____

Accidents: (examples: broken bones, loss of consciousness or overdosing?)_____

_____ _____

Hospitalizations? If yes, why?_____

Surgeries?_____

Family History: circle all that apply to any close relative

High blood pressure	Hives	Hay fever	Cancer
High Cholesterol	Lung disease	Foot problems	Anemia
Heart attack before age 60	Nervous disease	Kidney/bladder	Skin disorder
Diabetes	Bone disease	Mental retardation	Thyroid disease
Obesity	Breathing problems	Learning disorders	Arthritis
Deafness	Allergy	Vision problems	Muscle disease
Seizure disorder	Colitis	Migraine Headaches	Bleeding problems
Scoliosis	Alcoholism	Smoking	

Please describe if any above applies.

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