



BROOMFIELD FAMILY PRACTICE: HEALTH HISTORY QUESTIONNAIRE: 17 & Under

Legal Name: _____ Date of Birth: _____ Nickname: _____
 Mothers Name: _____ Date of Birth: _____ Occupation: _____
 Fathers Name: _____ Date of Birth: _____ Occupation: _____
 Daytime Phone: _____ Evening Phone: _____
 Address: _____

Race: _____ Ethnic Background: _____ Language: _____

Social History:

Who does your child live with? _____

If parents are divorced, what is the custody arrangements? _____

Siblings' Names and Birthdates: _____

Does anyone besides the parents and siblings live in the house? If so, whom? _____

Child's School? _____ Grade: _____

Are there any pets in the home? _____

Are there any smokers in the home? _____

Medications:

Medication:	Dose	How Many Times a Day
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication Allergies: ___ No ___ Yes

If Yes, to what medication(s) and what was the reaction? _____

Immunization History: (Please bring a copy of immunizations to our office)

To the best of my knowledge, my child is up to date on his/her immunizations: ___ No ___ Yes

If no, why? _____

Birth History:

Please indicate any medical problem during pregnancy? _____

Please list any medications taken during pregnancy? _____

Any drug or alcohol use during pregnancy? ___ No ___ Yes

Delivered by? ___ Elective C- Section ___ Forceps ___ Vacuum Extraction ___ Normal Vaginal Delivery

If not a normal vaginal delivery, why: _____

Birth weight? _____

Please indicate any medical problems during the newborn period: _____

Hospitalizations:

Has your child ever stayed overnight in a hospital? ___ No ___ Yes

If yes, when and why? _____

Surgical History:

Please indicate any surgeries or procedures your child has had. Please include the year the surgery/procedure was performed: _____

GYN History:

Age of first period _____ First day of last period _____ Has not had menses yet _____

Personal Medical History: Please check if your child has any of the following medical problems

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Headaches | <input type="checkbox"/> Liver disease/Hepatitis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Concussion | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Recurrent Ear Infections |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Urinary Tract Infections |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Fracture | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Vesicoureteral Reflux |
| <input type="checkbox"/> Bronchiolitis | <input type="checkbox"/> Handicaps/Disabilities | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Vision Problems |

Family History: Please indicate if your child has family history (parents, siblings, grandparents, aunts, uncles, or cousins to the child) of any of the following:

Diagnosis	Family Member	Diagnosis	Family Member
<input type="checkbox"/> ADD/ADHD	_____	<input type="checkbox"/> Hearing Disability	_____
<input type="checkbox"/> Alcohol/Drug Abuse	_____	<input type="checkbox"/> High Cholesterol	_____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> HIV/AIDS	_____
<input type="checkbox"/> Birth Defects	_____	<input type="checkbox"/> Intellectual Disability	_____
<input type="checkbox"/> Blood Disorders	_____	<input type="checkbox"/> Learning Disability	_____
<input type="checkbox"/> Cancer, Type	_____	<input type="checkbox"/> Mental Illness	_____
<input type="checkbox"/> Heart Disease (heart attack, bypass, stents)	_____	<input type="checkbox"/> Migraines	_____
<input type="checkbox"/> Deafness/Hearing Problems	_____	<input type="checkbox"/> Scoliosis	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Seizure Disorder	_____
<input type="checkbox"/> Developmental Delay	_____	<input type="checkbox"/> Speech Problems	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> TB/Lung Disease	_____
<input type="checkbox"/> Genetic Disorder	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Hepatitis/Liver disease	_____	<input type="checkbox"/> Thyroid Disease	_____
		<input type="checkbox"/> Other	_____

Would you like to use our *SECURE* Healthcare Email to communicate with your child's provider?

No ___ Yes, email address _____

Parent Signature

Date