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

___ ADD/ADHD	_____ Chicken Pox	_____ Headaches	_____ Liver disease/Hepatitis
___ Allergies	_____ Concussion	_____ Hearing Problems	_____ Recurrent Ear Infections
___ Anemia	_____ Diabetes	_____ Heart Murmur	_____ Seizures
___ Asthma	_____ Eczema	_____ Congenital Heart Disease	_____ Urinary Tract Infections
___ Bleeding Disorder	_____ Fracture	_____ High Blood Pressure	_____ Vesicoureteral Reflux
___ Bronchiolitis	_____ Handicaps/Disabilities	_____ Kidney Disease	_____ 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
___ ADD/ADHD	_____	_____ Hearing Disability	_____
___ Alcohol/Drug Abuse	_____	_____ High Cholesterol	_____
___ Allergies	_____	_____ High Blood Pressure	_____
___ Asthma	_____	_____ HIV/AIDS	_____
___ Birth Defects	_____	_____ Intellectual Disability	_____
___ Blood Disorders	_____	_____ Learning Disability	_____
___ Cancer, Type	_____	_____ Mental Illness	_____
___ Heart Disease (heart attack, bypass, stents)	_____	_____ Migraines	_____
___ Deafness/Hearing Problems	_____	_____ Scoliosis	_____
___ Depression	_____	_____ Seizure Disorder	_____
___ Developmental Delay	_____	_____ Speech Problems	_____
___ Diabetes	_____	_____ TB/Lung Disease	_____
___ Genetic Disorder	_____	_____ Stroke	_____
___ Hepatitis/Liver disease	_____	_____ Thyroid Disease	_____
		_____ Other	_____

Would you like to use our *SECURE* Healthcare Email to communicate with your child's provider?
No ____ Yes, email address _____

_____ _____

Parent Signature Date