

## HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your child's health care provider better understand your child's medical concerns and conditions. If you cannot remember specific details, please approximate. Add any notes you think are important. **ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.**

Main reason for today's visit: \_\_\_\_\_ Other concerns: \_\_\_\_\_

**CURRENT MEDICATIONS – Please list the medications your child currently takes. If he/she is not currently taking any medications, please check the "none" box to the right.**  None

Name of Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		

**MEDICATION/ALLERGY SENSITIVITY**  
List all medications your child is allergic to:  None

1.
2.
3.
4.

**YOUR CHILD'S PROVIDERS – Please list the doctors your child sees in the community.**

1.
2.

**PHARMACIES – list the address and phone number for pharmacies, both local and mail away.**

1.
2.

**PAST MEDICAL HISTORY - Please check the box if your child has had or experienced these symptoms or medical issues. If none, indicate by checking the "none" box to the right.**  None

<input type="checkbox"/> ADD or ADHD	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Allergies	<input type="checkbox"/> Congenital Anomalies	<input type="checkbox"/> Hospital Admission other than birth
<input type="checkbox"/> Anemia	<input type="checkbox"/> Constipation	<input type="checkbox"/> Muscle, Joint, or Bone Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Seizures/Epilepsy
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Developmental or Behavioral Disorders	<input type="checkbox"/> Serious Illness or Injuries
<input type="checkbox"/> Bladder or Kidney Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Skin Problems
<input type="checkbox"/> Blood Diseases	<input type="checkbox"/> Ear or Hearing Problems	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Eczema, Hives, or other skin conditions	<input type="checkbox"/> Vision or Eye Problems
<input type="checkbox"/> Other:		

**SURGICAL PROCEDURES**  More than four

Month/Year	Illness/Operation	Complication (Y/N)

*To my understanding, this represents an accurate portrayal of my child's health history. I will inform Apple-A-Day Pediatrics as changes or updates occur.*

\_\_\_\_\_  
Patient Representative Signature Relationship Date