Peninsula Community Health Services

HEALTH HISTORY QUESTIONNAIRE (PEDIATRIC)

Name: _____ **DOB:** _____ **Age:** _____

Primary Care Provider: _____

MEDICAL HISTORY *(MARK ALL THAT APPLY TO YOUR MEDICAL HISTORY)*

Is your child taking any medications or supplements from any Provider outside PCHS? ❒ No ❒ Yes

Does your child have any known allergies? ❒ No ❒ Yes What are they allergic to? _____ _____ _____

What kind of allergic reaction (*additional space on the back of form*)? _____

Any recent hospitalization? ❒ No ❒ Yes Date: _____ Reason: _____

History of broken bones? ❒ No ❒ Yes Date: _____ Which bone(s)? _____

❒ ADD/ADHD	❒ Anxiety	❒ Depression	❒ High Blood Pressure	❒ Seizure Disorder
❒ AIDS/HIV	❒ Arthritis	❒ Diabetes	❒ Heart Problems	❒ Thyroid Disease
❒ Allergies	❒ Asthma	❒ Edema	❒ Kidney Disease	Other: _____
❒ Anemia	❒ Cancer	❒ High Cholesterol	❒ Liver Disease	Other: _____

PAST SURGICAL HISTORY

Procedure	Year	Procedure	Year	Procedure	Year
❒ Abdominal Surgeries		❒ Gallbladder Removal		❒ Tonsil Removal	
❒ Appendix Removal		❒ Heart Surgery		❒ Tubes in Ears	
❒ Back Surgery		❒ Hernia Repair		❒ Other Surgery	
❒ Bladder Surgery		❒ Knee Surgery			
❒ Colon Surgery		❒ Thyroid Surgery			

GENDER SPECIFIC

Male	Year
❒ Circumcision	

Female	Year
Other:	

FAMILY HISTORY *(mark all that apply to your birth family history)*

❒ Family History Unknown Number of Siblings (Brothers and Sisters)? _____

Condition	Mother	Father	Sibling	Family H/O	Condition	Mother	Father	Sibling	Family H/O
ADD/ADHD	❒	❒	B/S	❒	High Blood Pressure	❒	❒	B/S	❒
Alcoholism	❒	❒	B/S	❒	High Cholesterol	❒	❒	B/S	❒
Allergies	❒	❒	B/S	❒	Irritable Bowel Disease	❒	❒	B/S	❒
Alzheimer's Disease	❒	❒	B/S	❒	Kidney Disease	❒	❒	B/S	❒
Arthritis	❒	❒	B/S	❒	Mental Illness	❒	❒	B/S	❒
Asthma	❒	❒	B/S	❒	Migraines	❒	❒	B/S	❒
Bleeding Problems	❒	❒	B/S	❒	Osteoporosis	❒	❒	B/S	❒
Cancer	❒	❒	B/S	❒	Seizure Disorder	❒	❒	B/S	❒
Heart Problems	❒	❒	B/S	❒	Stroke	❒	❒	B/S	❒
Depression	❒	❒	B/S	❒	Vascular Disease	❒	❒	B/S	❒
Diabetes	❒	❒	B/S	❒	Other: _____	❒	❒	B/S	❒
Heart Attack	❒	❒	B/S	❒	Other: _____	❒	❒	B/S	❒

REVIEW OF SYSTEMS – RECENT PROBLEMS (LAST 30 DAYS)

❒ Acting Fussy	❒ Eye Redness	❒ Chest Pain	❒ Depression
❒ Acting/Feeling Tired	❒ Headache	❒ Hands or Feet Cold or Blue	❒ Loss of Interest
❒ Chills	❒ Hearing Loss	❒ Constipation	❒ Growing Moles or Birthmarks
❒ Decreased Appetite	❒ Problems Swallowing	❒ Diarrhea	❒ Itching
❒ Fever	❒ Running Nose	❒ Spitting up Frequently/Heartburn	❒ New Lumps or Masses
❒ Increased Appetite	❒ Sneezing	❒ Vomiting	❒ Rashes
❒ Insomnia	❒ Throat Pain	❒ Bedwetting	❒ Skin Changes
❒ Congestion	❒ Cough	❒ Blood in Urine	❒ Pain or Lumps in Breast
❒ Change in Vision	❒ Problems Breathing	❒ Decreased Urine	❒ Joint Pain
❒ Dizziness	❒ Short of Breath with Activity	❒ Urine Odor	❒ Muscle Pain
❒ Ear Drainage	❒ Wheezing	❒ Painful Urination	❒ Other: _____
❒ Ear Pain	❒ Fast or Irregular Heartbeat	❒ Increased Urine	❒ Other: _____
❒ Eye Drainage	❒ Passing Out	❒ Anxiety	

For Males: ❒ Discharge from Penis ❒ Skin Changes on Penis ❒ Pain/Lumps Testicles or Scrotum

For Females: ❒ Vaginal Discharge ❒ Vaginal Bleeding or Spotting ❒ Pain or Itching ❒ Pain or Lumps in Breast

Please Turn Over

Peninsula Community Health Services

HEALTH HISTORY QUESTIONNAIRE (PEDIATRIC)

SOCIAL HISTORY

Born by **Vaginal** delivery or **C-section** (*circle one*) Birth Weight: _____

How many servings of fruits or vegetables does your child eat a day? (*one serving = approx. palm of hand*) _____

How many times a week does your child:

Eat Dinner at the Table with Family _____ Eat Breakfast _____ Eat Take Out or Fast Food _____

How many 8-ounce servings of the following does your child drink a day?

100% Juice _____ Soda/Fruit Punch/Energy Drinks _____ Water _____

Whole Milk _____ Nonfat or Reduced Fat Milk _____

School Name: _____ Grade: _____

Learning Disability? ❒ No ❒ Yes Special Needs? ❒ No ❒ Yes

Performing? ❒ Below Grade Level ❒ At Grade Level ❒ Above Grade Level

How much time every day does your child watch TV/movies or sit and play video/computer games? _____

How much time every day does your child spend being physically active (*faster breathing/heart rate or sweating*)? _____

Is there a TV or computer in your child's bedroom? ❒ No ❒ Yes

Resides With: _____ Child Care: _____

Do any smokers live in the house? ❒ No ❒ Yes Do people smoke **Inside** or **Outside** the house (*circle one*)?

Any pets? ❒ No ❒ Yes Types of Pets: _____

Any pools, hot tubs, rivers or ponds near the house?	❒ No	❒ Yes	Toilet Trained?	❒ No	❒ Yes
Ride in car seat, booster, or wear seat belt in car?	❒ No	❒ Yes	Bedwetting?	❒ No	❒ Yes
Wear helmets when riding bike/scooter/skating?	❒ No	❒ Yes	Concerns about Diet?	❒ No	❒ Yes
Are there any guns/weapons in the home?	❒ No	❒ Yes			

If **Yes,** how are the guns/weapons stored? _____

Is religion/spirituality an important part of your life? ❒ No ❒ Yes Religion Preference: _____

MEDICATIONS (*USE ADDITIONAL PAPER IF MORE SPACE IS NEEDED*)

NAME:	STRENGTH :	HOW MANY TIMES A DAY:

COMMENTS *(additional information Provider should know about your Health History)*

Provider Signature **Date**

Name:_____ DOB:_____ MRN:_____