link COMMUNITY CLINIC

NEW PEDIATRIC PATIENT HEALTH QUESTIONNAIRE

Please use the back of this page if you need more space for your responses

Last Name, First Name (Preferred): _____ **DOB:** _____

Name of person filling out the form: _____ **Relationship to patient:** _____

Gender *Please circle* female male not listed _____

Sex assigned at birth *Please circle* female male intersex not listed _____

Your answers to the following questions will help us understand your or your child's medical history. Please fill out as much information as possible. If you cannot answer a question or feel uncomfortable answering a question, please leave them blank. Thank you for your help.

Household Members *Please list all household members that live with the patient. Overflow space on back of page.*

Name	Relationship to child	Birth date	Health Problems

☐ Adopted ☐ Foster care ☐ Parents divorced/separated ☐ Joint custody parents (incl. married) ☐ Single custody parent

Birth History

Birth weight _____lbs _____ oz	☐ Full term birth	☐ Premature ____ wks	☐ Vaginal birth	☐ C-section
Hospital name_____		Hospital City, State_____		
☐ Pre-/neo-natal complications? Explain: _____			☐ NICU Stay - How long? _____ weeks	
☐ Tobacco use during pregnancy	☐ Alcohol use during pregnancy		☐ Medication/drug use during pregnancy	

Medical History *Please check or list any medical problems your child has experienced.*

☐ Problems with hearing or ears	☐ Problems with vision or eyes	☐ Allergies
☐ Asthma or wheezing	☐ Heart murmur or heart disorder	☐ Depression/Anxiety/ADHD/Mood disorder
☐ Headaches/migraines	☐ Kidney disease or recurring UTIs	☐ History of head injury or concussion
☐ Seizures	☐ Substance use or abuse	☐ Snoring/Obstructive sleep apnea
☐ Surgeries - Type of surgery/year? _____		☐ Other _____

Family Medical History *Please check or list any medical problems in your child's biological family.*

☐ Asthma	*Who?*	☐ Early sudden death	*Who?*
☐ Cancer	*Who?/Type?*	☐ High cholesterol	*Who?*
☐ Depression/Anxiety/Mental Illness	*Who?*	☐ Diabetes	*Who?*
☐ Stroke/Cardiovasc. dz/Heart attack < age 55y	*Who?*	☐ Substance abuse	*Who?*
☐ High blood pressure	*Who?*	☐ Childhood hearing loss	*Who?*
☐ Other	*What/Who?*		

Physical Activity How many days does your child engage in strenuous physical activity (walking/running/swimming/dancing/etc)?
days in a week: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

On average, how many minutes does your child engage in exercise at this level each time?
☐ 0 ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50 ☐ 60 ☐ 70 ☐ 80 ☐ 90 ☐ >90

Medications/Supplements *Please list all names and doses of medications/supplements/vitamins and conditions for which they are taken.*

Medication or supplement	Dose and how often	Condition

Medication Allergies *Please list the name of the medication and the reaction your child experienced.*

Medication	Reaction

Other Healthcare Providers *Please list your child's previous doctor and any specialists (e.g, allergist, counselors, etc.) that care for your child.*

Doctor's/Care Provider's Name	Type of physician/specialty and Location

Thank you for your time. Your child's medical history is very important to us!

Household Members *Overflow*

Name	Relationship to child	Birth date	Health Problems

Medications/Supplements *Overflow*

Medication or supplement	Dose and how often	Condition

Medication Allergies *Overflow*

Medication	Reaction

Other Healthcare Providers *Overflow*

Doctor's/Care Provider's Name	Type of physician/specialty and Location

Any addition al comments/information you would like to include: