CHILD QUESTIONNAIRE

Patient: ______________________ DOB: ______________________ Date: ____________

Your child's medication, medication allergies, and past health problems are an important part of their diagnosis and treatment plan. Please try to answer all questions fully.

What kind of problem is your child having? ______________________

Which Healthcare Provider referred your child to our office? ______________________

What medications is your child currently taking? (If you have a list, please let us make a copy of your list.)

What medication allergies does your child have?

Please list any health problems that your child has:

Please list any surgeries your child has had in the past:

Does anyone smoke in the home? Yes _____ No _____

Does your child go to daycare? Yes _____ No _____

How many other children are there in your household? _____ What are their ages? ______________________

Birth History:

Was your child born at term? Yes _____ No _____

Please list any other information you think your physician should know about your child's health:

Physician Initials _____ Date ________

NEW PATIENT QUESTIONNAIRE

The following list reviews a number of health problems. Please place a check mark if you or your family has experienced any of these health problems.

	Problem	Patient	Family	Comments
General	Fever/chills Weight change			
Birth	Premature birth Difficult delivery Jaundice			
Ear, Nose, & Throat	Nosebleeds Tonsillitis Ear infections Hearing loss Hearing aid use Inner ear problems Enlarged lymph nodes			
Allergy	Hayfever Animal reactions Food reactions Latex reactions			
Lung	Asthma Chronic cough Bronchitis or pneumonia			
Heart	Heart disease High blood pressure			
GI	Acid reflux / heartburn Colic Diarrhea / constipation Hepatitis / jaundice			
Eye	Glasses Eye Surgery			
MS	Arthritis Back problems Neck injury Muscle weakness			
Skin	Hives or rashes Eczema			
Neurologic	Seizures Developmental delay Neurologic problems Speech delay Migraines			
Endocrine	Diabetes Thyroid problems			
Psychiatric	Behavioral problems ADHD Depression Anxiety			
Immune	Bleeding disorders Hereditary anemia			

Physician Initials ______ Date __________