South Royalton Health Center

Pediatrics and Adolescent Medicine

Rebecca A. Foulk, M.D   Ashley A. Miller, M.D.   Samuel B. McWilliams, M.D.
Frank B. Lamson, C.P.N.P.   Anita M. Onofrio, C.N.M.   Kimberly J. Therrien, L.I.C.S.W.

Health Questionnaire

Date: **Child's Name:**   **Birth date:**

The purpose of the questionnaire is to help us obtain information about your child and family to aid us in providing the best health care possible. The questions are designed to determine if your child has any problems now or in the recent past, any past history that may be important, and to identify risk for future problems. Please answer all questions as they apply to your child. If a question does not apply or you prefer not to answer, leave it blank. If you do not understand a question, please circle the number so we can explain it further. This questionnaire will become part of your child's health record, and as such will be strictly confidential.

Filled out by: **Relationship to child:**

Chief complaint and general health

1. What is the main reason your child is being seen today?
2. Are there any problems you are concerned about or questions you would like to have answered? yes no
3. How would you describe your child's general health? (excellent, good, fair, poor)
4. In the past year has your child missed more than seven days of school because of illness? yes no
5. In the past year has your child taken any medication for more than two weeks? yes no
6. Has your child ever been hospitalized? Had surgery? yes no

If yes, please list below:

Date	Problem	Hospital	Doctor

7. Has your child ever been involved in a serious accident or had an accidental poisoning? yes no
8. Did you have any problems during your pregnancy with this child? yes no
9. Were you on any medications during your pregnancy with this child? yes no
10. Was your child born more than two weeks early or more than two weeks late? yes no
11. What was your child's birth weight?________lbs. ________oz.
12. Did your child have any problems immediately following birth? yes no
13. At what age did your child: sit alone_______ dress him/herself_______
    walk_______ tie his/her shoes_______
    speak sentences_______

14. Do you have any concerns about your child's development or learning disabilities? no
15. Has your child ever had to repeat a school grade?

yes

yes

no

Family Profile

16. Years at present address___________

17. Type of dwelling___________ Owned or rented___________

18. Father's Name__________________________Age________Education_____________________

Employment_______________________________Previous Marriage?_____________________

20. Mother's Name__________________________Age________Education_____________________

Employment_______________________________Previous Marriage?_____________________

21. Siblings:

Name(s)	Sex	Age

22. Other people living with your family:

Name(s)	Relationship	Age

23. Does anyone in your home have persistent medical problems?	yes	no
24. Are parents divorced or separated?	yes	no
25. Do you find it difficult to obtain medical care due to financial problems?	yes	no
26. Does anyone in your household smoke?	yes	no
27. Does your child drink more than a quart (32 oz.) of milk per day?	yes	no
28. Are there any unlocked firearms in your home?	yes	no
29. Does your child ride in a safe car seat?	no	yes
30. Do you and your children know what to do in case of an emergency?	no	yes
31. Is your water heater temperature set to 120 degrees or lower?	no	yes
32. Do you have smoke alarms in your home?	no	yes
33. Do you have carbon monoxide detectors in your home?	no	yes

Family History

Have any of your child's first-degree blood relatives (parents, grandparents, aunts, uncles, siblings or cousins) had any of the following? Circle all that apply.

mental retardation
seizures
psychiatric disorders
hearing loss
glaucoma, cataracts or other eye problems
asthma
allergies
cystic fibrosis
emphysema before age 40
tuberculosis
heart attack before age 50
high blood pressure
high cholesterol
diabetes
alcohol abuse
domestic violence
thyroid problems
obesity
stroke before age 50
ulcers
intestinal or rectal polyps
liver disease
kidney disease
hemophilia or other bleeding disease
rheumatoid arthritis
muscular dystrophy or other muscle disease
congenital malformations or deformities
death in infancy or childhood
cancer
eczema or psoriasis
drug abuse
migraines
disease of the nervous system (e.g. multiple sclerosis)
spherocytosis or other bleeding disorders

Has your child had any of the following? Circle all that apply.

unexplained fever
poor appetite
loss of weight
excessive weight gain
excessive thirst
serious head injury
loss of consciousness
dizzy or fainting spells
frequent headaches
difficulty seeing or “lazy eye”
earaches
difficulty hearing
frequent nose bleeds
frequent runny or stuffy nose
toothaches
many cavities
chronic cough
wheezing or shortness of breath
frequent sore throat
unnatural tiredness
heart murmur
rapid or irregular heartbeat
frequent stomach aches
frequent vomiting or diarrhea
constipation
blood in bowel movements
complaints of pain while urinating
a need to urinate frequently
excessive amounts of urine
bed wetting
blood in urine
abnormal development of sex organs
abnormal growth
jaundice
excessive vaginal discharge
menstrual periods
bladder or kidney infection
broken bones
pain or stiffness in joints or back
limp for over a week
swollen joints
rashes, hives or skin problems
many bruises or bleeding for a long time period
many temper tantrums
difficulty getting to or remaining asleep
nightmares
other special fears
difficulties in school
behavioral problems
anemia
hair loss

We thank you for your cooperation and time in helping us provide optimal care for your child.