SCITUATE FAMILY PRACTICE
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Name: _____

Date of Birth: _____

CHILD HEALTH HISTORY QUESTIONNAIRE

Please answer as best as possible. All answers will be kept confidential.

How did you hear about this practice? _____

PAST MEDICAL HISTORY

Past/Current Medical Problems: _____

_____

_____

Operations/Hospitalizations (date, reason): _____

_____

Medications (with dose): _____

_____

Any Known Allergies to Medications: □No □Yes Which?: _____

PERSONAL HISTORY

Tobacco: Do you smoke? □Yes □Quit □Never Packs/Day: ____ Age you began smoking:____
Does anyone else smoke in the home? □Yes □No
Have you tried alcohol or other drugs: □Yes □No _____
Regular Exercise: _____
Members of Household (name, relation): _____

_____

Places lived outside of US: _____
Does anyone hit or hurt you: □Yes □No

SOCIAL HISTORY

What is your current school and grade? _____

Average grades? Any troubles at school? _____

FAMILY HISTORY

Mother: Age, if living: ____ Health problems: _____

Father: Age, if living: ____ Health problems: _____

Number of brothers: ____ sisters: ____ Health problems: _____

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If any apply to your family, please indicate how the person is related:

Cancer: _____ Diabetes: _____ Depression: _____
types of cancer: Heart attack: _____ Stroke: _____

Other diseases: _____

REVIEW OF SYSTEMS

Which do you have, or have you had recently? Write in any other symptoms and circle any that concern you.

Do you often feel down, depressed or hopeless? □Yes □No
Do you often find little interest or pleasure in doing things: □Yes □No

GENERAL
- Weight change
- Change in appetite
- Sensitivity to heat or cold

EAR, NOSE, THROAT
- Trouble with hearing
- Trouble with vision
- Trouble with teeth or gums
- Hay fever/sinus problems
- Last eye exam: _____

HEART
- Chest pain or tightness
- Palpitations

RESPIRATORY
- Cough/wheezing
- Hoarseness
- Shortness of breath

NEUROLOGIC
- Headache
- Sleep problems

GASTROINTESTINAL
- Stomach pain
- Nausea or vomiting
- Diarrhea or constipation
- Blood in stool/black stool

URINARY
- Pain or burning
- Increased frequency
- Frequent urinary infections

MOOD
- Anxiety
- Panic attacks
- Depression

OTHER
- Acne
- Back pain
- Rashes
- Changing moles

IMMUNIZATIONS *(please provide year, if known)*

Influenza (Flu): _____

Person completing form: _____ Date: _____