

Annual Health Questionnaire

Name: _____ Date: _____

Indicate which of the following conditions or problems this child has ever had:

- Skin trouble ()
- Eye or vision problems ()
- Eyeglasses ()
- Frequent ear infections ()
- Difficulty hearing ()
- Frequent nose bleeds ()
- Nasal allergies ()
- Sinus problems ()
- Frequent sore throats ()
- Thyroid Problems ()
- Pneumonia ()
- Asthma ()
- Any other lung problems ()
- Heart Murmur ()
- Jaundice ()
- Frequent stomach aches ()
- Frequent diarrhea ()
- Frequent constipation ()
- Black or tarry stools ()
- Kidney or Bladder infection ()
- Painful Urination ()
- Bedwetting ()
- Painful Periods ()
- Irregular Periods ()
- Vaginal discharge ()
- Joint aches or pains ()
- Orthopedic or bony problems ()
- Seizures ()
- Frequent headaches ()
- Skin rashes ()
- Eczema ()
- Reactions to Insect Bites ()
- Anemia ()
- Behavior Problems ()
- Learning Problems ()
- Speech Problems ()
- Other _____ () _____

Give details and dates for problems checked:

Any allergy to food or medication?

Yes _____ No _____

If yes, please list them _____

List medications child is presently taking including vitamins & fluoride _____

Family History — Check any of the following diseases which relatives (including aunts, uncles, cousins, grandparents) have:

Seizure Disorder _____ Anemia or Blood Problems _____
Alcoholism _____

Tuberculosis	_____	Kidney Disease	_____
Hayfever	_____	Cystic Fibrosis	_____
Asthma	_____	Cancer	_____
High Blood Pressure	_____	Mental Retardation	_____
Heart Attack, Stroke (under 55 years of age)	_____	Birth Defects	_____
Diabetes	_____	Psychiatric Problems	_____
Obesity	_____	Death before 50 years of age, other than accident	_____
High Cholesterol or Triglycerides	_____		

Please give details of diseases checked here: _____

Please list cause of death of close relatives to this child:

Name	Relationship to Child	Cause of Death
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Psycho-Social History

What does child do in spare time? _____

Any special interests or hobbies? _____

How many hours a day does child watch TV? _____

Indicate any financial, interpersonal, or family problems you are worried about. _____

How is he/she doing in school? _____

Does he/she have good friends? _____

Does your child get easily upset? _____

Does he/she get into fights frequently? _____

Does he/she have any sleep difficulties? _____

Are you worried about your child's eating habits? _____

Present History

Are there any problems that concern you about this child now that you would like to discuss with the Pediatrician?

Parent/Gardian Signature: _____

Date: _____

Physician Reviewed _____