Flourish, LLC

Pediatric Health History Questionnaire

Please take the time to fill out this questionnaire carefully. If you have any questions, ask for assistance. If you have any concerns that are not listed, make not of them on the back of this form. The completed form will greatly assist us in providing a thorough evaluation of your (or your child's) health.

Name: _____ Date of Birth: _____ Date: _____

Parent(s)/guardian(s) name(s):_____

CONTEXT OF CARE

What brings you into the office today?

What are your main concerns? (Please list them in order of importance)

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

What long term expectations do you have from working with our clinic?

Are you currently receiving health care? (please circle) Yes No

If yes, where and from whom? _____

If no, when and where did you last receive health care? _____

What was the reason? _____

FAMILY HISTORY

Do you have a family history of any of the following (please circle)?

Cancer	Diabetes	Heart Disease	High Blood Pressure
Tuberculosis	Asthma	Arthritis	Mental Illness

Other relevant family history?

CHILDHOOD ILLNESSES

Please circle whether your child has had:

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Rheumatic Fever	Diptheria	Scarlet fever	Chicken Pox
German Measles	Measles	Mumps	Frequent colds

Please circle if your child has had the following? How many times?

Ear Infection	Tonsilitis	Strep throat

CURRENT MEDICATION LIST

Does your child take any of the following (please circle):

Aspirin	Tylenol	Ibuprophen	Antihistamine
Antibiotics	Decongestants	Others (list below)	

Please list any prescription medications, over the counter medications, vitamins, or other supplements that your child is taking with their dose:

1) _____ 3) _____

2) _____ 4) _____

ALLERGIES

Is your child hypersensitive or allergic to any of the following? What happens if you have a reaction?

Medications? _____

Foods? _____

Environment? _____

Other? _____

HOSPITALIZATIONS / DIGNOSTIC WORKUP

Has your child had any of the following? When? Where? What were the results?

Hosptalizations/Surgeries/ injuries

EEG

Hearing or speech tests

Psychological evaluations

IMMUNIZATIONS (please list date(s) next to each)

Hep B _____ Measles _____

DPT _____ Mumps _____

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Tetnus	_____	Rubella	_____
HIB	_____	Varicella (chicken pox)	_____
Pneumococcal	_____	Rotovirus	_____
MMR	_____	H influenza	_____
Hep A		Other	_____

Reactions?

PRENATAL HISTORY

Has the mother had previous pregnancies? Yes No If so when?
" " Miscarriages? Yes No
Complications? Yes No

Explanation _____

Mother's age at child birth _____ Father's age at childbirth _____

Did either or both parents have fertility issues prior? Yes No

Explain:

Did Mother have any of the following during pregnancy? (circle)

Bleeding
Nausea
Physical or Emotional Trauma
Other Illness _____
Hypertension (preeclampsia)
Diabetes
Thyroid problems

BIRTH HISTORY

Term: Full Premature: (how many weeks?)
Birth weight: _____ Length: _____

Length of Labor _____ Complications:_____

Did the child have any of the following shortly after birth?

Rashes
Jaundice
Birth Injuries
Other
Blue baby
Seizures
Cerebral palsy
Colic
Fever
Birth defects

CHILD'S HEALTH CONCERNS

CURRENT SYMPTOMS (circle or write P next to those they've had in the past)

Hives
Burning urine
Bloody urine
Eczema
Cries easily
Bleeding gums
Heart murmur
Nervous
Nose bleeds
Vomiting spells
Sleep problems
Asthma
Acne
Anemia
Night sweats

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High fevers	Flat feet	Joint pains
Jaundice	No appetite	Excessive fatigue
Sensitive to light	Body/breath odor	Cough
Chronic rash	Constipation	Dizzy spells
Stomach aches	Nightmares	Hair loss
Diarrhea	Frequent colds	Frequent urination
Hearing loss	Bleeding tendency	Allergies
Easy bruising	Unusual fears	
Sore throat	Wheezing	

DIET (what does (s)he eat in a typical day)

BREAKFAST _____

LUNCH _____

DINNER _____

SNACK _____

DRINKS _____

OTHER (please use the back if needed)

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