How did you hear about us?

_____

Carondelet Medical Group. Be well.

HEALTH HISTORY QUESTIONNAIRE - PEDIATRIC

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. For additional information write or attach on back.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**		**Date:**

PERSONAL HEALTH HISTORY

Medication - List your prescriptions include OTC drugs, such as vitamins and inhalers. ☐ **No medications taken**

Name the Drug	Strength	Frequency	Name the Drug	Strength	Frequency

Allergies- Include antibiotics, narcotics, anesthetics, Iodine, IV, dye, latex, insect bites, stings, food ☐ **No known allergies**

Name	Reaction	Name	Reaction

Specialists and Hospitalizations ☐ **No hospitalizations**

Specialists currently seen	
Recent Hospitalization in the last year	**Date:** **Location:**

Surgeries/Procedures ☐ **No Surgeries/Procedures**

☐ Appendectomy (Appendix)	Hysterectomy ☐ Partial ☐ Total	☐ Coronary Stent	☐ Vasectomy	☐ Knee Procedure
☐ Tonsillectomy	☐ Cesarean Section	☐ Coronary Bypass	☐ Prostate Procedure	☐ Hip Procedure
☐ Gall Bladder (Cholecystectomy)	☐ Tubal Ligation	☐ Heart Valve Surgery	☐ Colon Procedure	☐ Back Procedure
☐ Hernia Repair	☐ Breast Procedure/Surgery	☐ Cardiac Pacemaker	☐ Eye Procedure	☐ Sinus Procedure
☐ Other Surgeries:				

SOCIAL HISTORY AND HABITS

Tobacco (13 Years and older)	**Smoking Status:** ☐ Never smoker ☐ Former Smoker ☐ Current every day smoker ☐ Current some day smoker ☐ Heavy tobacco smoker ☐ Light tobacco smoker ☐ Unknown tobacco status	**Tobacco Type:** ☐ Cigarettes ☐ Cigars ☐ Oral ☐ Pipe ☐ Other:	**Describe your daily tobacco use**: _____ # Packs _____ # Cigarettes _____ # Chew/day	Previous Quit Attempts: ☐ None ☐ Counseling ☐ Hypnosis ☐ Medications ☐ Nicotine replacement
	_____ Number of Years	_____ Age Started	_____ Age Quit	
Alcohol (13 years or older)	Do you drink alcohol? ☐ Yes ☐ No	If yes, what type/amount per week?		
Hobbies	List hobbies, activities and sports:			
Drugs (13 years or older)	Do you use recreational drugs? ☐ Yes ☐ No	Type:	Amount:	
School	Does the child go to a babysitter, preschool, or day care?			
	Place of employment/school?			
Sexuality (13 years or older)	Are you sexually active? ☐ Yes ☐ No	If yes, are you using birth control? ☐ Yes ☐ No		
	Have you ever been pregnant? ☐ Yes ☐ No	Do you feel threatened in relationships? ☐ Yes ☐ No		

Doctor/Clinician Signature: _____Date:_____

Carondelet Medical Group. Be well.

Name (Last, First, M.I.):		DOB:	Date:

SOCIAL HISTORY AND HABITS

Personal/Safety

List all people in the household:

Name	Date of Birth	Occupation	Highest level of education completed

Does the child have a second household?	☐ Yes ☐ No
Does the child wear seatbelts and biking helmets?	☐ Yes ☐ No

REVIEW OF SYMPTOMS

Please check any of the following you had had within the last 3 months.

GENERAL	**GASTROINTESTINAL**	**NEUROLOGICAL**
☐ Unintended weight change	☐ Difficulty swallowing	☐ Arm/leg numbness/weakness/tingling
☐ Always tired/fatigue	☐ Abdominal pain	☐ Balance problem/dizziness/vertigo
☐ Appetite change	☐ Nausea	☐ Fainting
☐ Unexplained fever/sweats	☐ Heartburn/Ulcer	☐ Significant headache
☐ Frequent sleep problem	☐ Bloating	☐ Head injury
EYES/EARS/NOSE/THROAT	☐ Vomiting/Vomiting blood	☐ Memory loss/Confusion
☐ Visual change	☐ Diarrhea	☐ Paralysis
☐ Difficulty Hearing	☐ Constipation	☐ Seizures/Convulsions
☐ Earaches	☐ Bloody or black stools	**MUSCULOSKELETAL**
☐ Frequent nosebleeds	☐ Special diet	☐ Back Pain
☐ Sneezing	**GENITOURINARY/GYN**	☐ Difficulty walking/Falls
☐ Sore/bleeding gums	☐ Blood in urine	☐ Joint swelling/Joint Pain
☐ Dental problems	☐ Frequent urination	☐ Joint swelling/Joint Pain
☐ Sore Throat	**ENDOCRINE**	**SKIN**
☐ Hoarse	☐ Excessive thirst	☐ Abnormal bleeding/bruising
☐ Swollen Glands	☐ Heat/cold intolerance	☐ Mole color/size change
☐ Wear Glasses	**CARDIOVASCULAR**	☐ Change in hair/nails
RESPIRATORY	☐ Chest pain	☐ Rash/itching/dry
☐ Cough/Pain with breathing	☐ Palpitations/irregular pulse	☐ Skin Ulcer
☐ Shortness of breath	☐ Leg pain when walking	☐ Acne
☐ Wheezing	☐ Swelling in legs or arms	**PYSCHOSOCIAL**
☐ Sleeping "propped up"		☐ Feeling down, depressed, or hopeless?
☐ Home Oxygen		☐ Little interest or pleasure in doing things?

☐ Other symptoms not listed above:

☐ Please check here if all are normal/ negative

Doctor/Clinician Signature: _____Date:_____

Carondelet Medical Group. Be well.

Name (Last, First, M.I.):		DOB:	Date:

FAMILY HEALTH HISTORY							
Do you have a parent, sibling, child with the following? Please select the family member. ☐ **Unknown** ☐ **Adopted**							
	Father	Mother	Other-How related?		Father	Mother	Other-How related?
☐ Cancer :Ovarian/Uterine	☐	☐	☐	☐ Osteoporosis	☐	☐	☐
☐ Cancer: Breast	☐	☐	☐	☐ High Blood Pressure	☐	☐	☐
☐ Cancer: Prostate Cancer	☐	☐	☐	☐ Mental illness	☐	☐	☐
☐ Cancer: Colon	☐	☐	☐	☐ Thyroid Disease	☐	☐	☐
☐ Cancer Other Type?	☐	☐	☐	☐ Stroke	☐	☐	☐
☐ Diabetes	☐	☐	☐	☐ Glaucoma	☐	☐	☐
☐ Heart Disease	☐	☐	☐	☐ Other :	☐	☐	☐

PEDIATRIC HEALTH		
Development – Do you have any concern about the following? If Yes, please explain.		
Behavior	☐ Yes ☐ No	
Eating habits	☐ Yes ☐ No	
Sleeping habits	☐ Yes ☐ No	
School experience	☐ Yes ☐ No	
Discipline	☐ Yes ☐ No	
Bullying	☐ Yes ☐ No	
Other (explain)	☐ Yes ☐ No	

Child General Health	☐ Good ☐ Fair ☐ Poor Explain, If Poor or Fair:		
Changes or Stress	Have there been any recent major changes or stresses in the child's life? ☐ Yes ☐ No		
Immunizations	Have immunization record? ☐ Yes ☐ No		
	Place where child received last vaccine:		
Providers/Specialist	Name(s) of other providers/specialists your child sees:		
Infants Only			
Birth History	Weight:	Length:	Place:
Pregnancy History	During the pregnancy, did the mother:		
	Have any medical problems?		☐ Yes ☐ No
	Smoke or drink?		☐ Yes ☐ No
	Use any medications?		☐ Yes ☐ No
	Use alcohol or other drugs?		☐ Yes ☐ No
	Have problems with labor/Delivery?		☐ Yes ☐ No

PREFERRED PHARMACY	
At which pharmacy do you prefer to pick up prescriptions?	
Pharmacy Name:	
Address (or cross-streets if address not known)	

Doctor/Clinician Signature: _____Date:_____