Please complete the following questionnaire. If this is for a new patient, please complete ALL sections (FRONT AND BACK). If you are a returning patient, please complete sections I,II,and III. When completed, please return to one of the nursing staff

Patient History Questionnaire	**Patient's Name** _____ Last Name First Name		
Today's Date: / /	**Birth Date:** / /	**Age**	☐**M** ☐**F**

I. Social History

Parent/Guardian Name(s) : _____
Number of Siblings: _____
Current School: _____
Current Grade Level: _____

Patient smoking status: ☐Never ☐Current ☐Former
Does anyone smoke in the home?: ☐Yes ☐No

II. General History

Do you consider your child to be in good health? ☐Yes ☐No Explain_____
Does your child have any serious medical conditions? ☐Yes ☐No Explain_____
Has your child had any surgery? ☐Yes ☐No Explain_____
Has your child ever been hospitalized? ☐Yes ☐No Explain_____
Is your child allergic to any medications or drugs? ☐Yes ☐No Explain_____
Is your child currently taking any medications? ☐Yes ☐No Explain_____

III. Development

Are you concerned about your child's physical development? ☐Yes ☐No Explain_____
Are You concerned about your child's mental or emotional development? ☐Yes ☐No Explain_____
Are you concerned about your child's attention span? ☐Yes ☐No Explain_____

If your child is in school:
How is his/her behavior in class_____
Has he/she failed or repeated a grade in school?_____
Is he/she in special or resource classes? _____
Have there been any changes to your child's medical history or family history since your last visit? ☐**Yes** ☐**No**
If yes, please complete remainder of form. If no, then you may stop and return form to one of the nurses.

IV. Past History

Does your child have or has he/she ever had any of the following conditions?

Chicken pox	☐Yes ☐No	Bladder/Kidney infection	☐Yes ☐No
Frequent ear infections	☐Yes ☐No	Bed Wetting after age 5	☐Yes ☐No
Nasal allergies	☐Yes ☐No	(Girls) Started menstrual periods?	☐Yes ☐No
Problems with eyes/vision	☐Yes ☐No	(Girls)Any problems with her periods?	☐Yes ☐No
Asthma/bronchitis/bronchiolitis/pneumonia	☐Yes ☐No	Chronic skin problems (acne/eczema/etc.)	☐Yes ☐No
Heart problems/Heart murmur	☐Yes ☐No	Frequent Headaches?	☐Yes ☐No
Anemia or bleeding problems?	☐Yes ☐No	Convulsions or other neurologic problems?	☐Yes ☐No
Blood transfusion	☐Yes ☐No	Diabetes?	☐Yes ☐No
Frequent abdominal pain	☐Yes ☐No	Thyroid or other endocrine problems?	☐Yes ☐No
Constipation	☐Yes ☐No	Use of alcohol or drugs?	☐Yes ☐No

Does your child have any other significant medical history?_____
_____
_____

V. Family History

Have any immediate family members (Patient's siblings, parents, and grandparents) been diagnosed with any of the following conditions:

Asthma ☐Yes ☐No Who _____
Heart disease (<age 55) ☐Yes ☐No Who _____
Sudden unexplained death ☐Yes ☐No Who _____
Breast cancer ☐Yes ☐No Who _____
Colon cancer ☐Yes ☐No Who _____
Prostate cancer ☐Yes ☐No Who _____
ADD/ADHD ☐Yes ☐No Who _____
Alcoholism ☐Yes ☐No Who _____
Atopic Disease/eczema ☐Yes ☐No Who _____
Autism ☐Yes ☐No Who _____
Bipolar Disorder ☐Yes ☐No Who _____
Bleeding Disorder ☐Yes ☐No Who _____
Blindness ☐Yes ☐No Who _____
Coronary artery disease ☐Yes ☐No Who _____
Celiac Disease ☐Yes ☐No Who _____
Colon polyps ☐Yes ☐No Who _____
Crohn's Disease ☐Yes ☐No Who _____
CVA or Stroke ☐Yes ☐No Who _____
Depression ☐Yes ☐No Who _____
CDH(Congenital Dysplasia of hip) ☐Yes ☐No Who _____
Diabetes ☐Yes ☐No Who _____
Drug Abuse ☐Yes ☐No Who _____
Food Allergy ☐Yes ☐No Who _____
Hearing Loss ☐Yes ☐No Who _____
Hemochromatosis ☐Yes ☐No Who _____
Huntington's disease ☐Yes ☐No Who _____
Blood clotting disorder ☐Yes ☐No Who _____
High cholesterol ☐Yes ☐No Who _____
High blood pressure ☐Yes ☐No Who _____
Inflammatory bowel disease ☐Yes ☐No Who _____
Irritable bowel disease ☐Yes ☐No Who _____
Learning Disabilities ☐Yes ☐No Who _____
Lung Cancer ☐Yes ☐No Who _____
Melanoma ☐Yes ☐No Who _____
Migraine ☐Yes ☐No Who _____
Developmental Disorder ☐Yes ☐No Who _____
Osteoporosis ☐Yes ☐No Who _____
Ovarian Cancer ☐Yes ☐No Who _____
Pancreatic Cancer ☐Yes ☐No Who _____
Renal (kidney) Disease ☐Yes ☐No Who _____
Schizophrenia ☐Yes ☐No Who _____
Seizures/epilepsy ☐Yes ☐No Who _____
Short Stature ☐Yes ☐No Who _____
Sickle Cell Disease ☐Yes ☐No Who _____
Sickle Cell trait ☐Yes ☐No Who _____
Skin Cancer ☐Yes ☐No Who _____
Suicide ☐Yes ☐No Who _____
Thyroid Disorder ☐Yes ☐No Who _____
Ulcerative Colitis ☐Yes ☐No Who _____
Vesicoureteral reflux (VUR) ☐Yes ☐No Who _____
Other heart disease: ☐Yes ☐No Who _____

Additional Family History:

_____
_____
_____
_____
_____
_____
_____