Dear Parent,

By filling out this questionnaire a more complete record of your child is obtained. It also gives us permanent history which we can refer to later. It saves you time and ours. Answer any questions you can, do not worry about those you skip. We will discuss with you any items which either you or we believe should be explained more fully.

Patient's Last Name **First Name** **Age** **Date**

Medical History

At how many weeks was your child born?	
Birthweight:	
After being born, did your child have troubles in the hospital?	

Does your child have:

Condition:	**Yes**	***No***
Food or Medication allergies		
History of surgery or hospitalization		
Frequent constipation		
Frequent diarrhea or vomiting		
Abdominal pain often		
Nasal allergies		
Asthma or recurrent wheezing		
Eczema or hives		
Ear Infections		
Recurrent sinus infections or pneumonia		
Hearing problems		
Vision problems		
Dental problems		
Urinary tract infections or urinary problems		
Seizures		
Headaches		

Do you have concerns about your child's:

Concern:	Yes	No
Behavior		
Development		

Family History

Please list the name and any medical conditions for each parent.

Parent name	Medical Condition, if any

Please list the names of the child's siblings and medical conditions if any.

Sibling name	Medical condition if any

Check any of the following conditions that the child's family member has had. Please provide the relationship of the family member to the child.

Medical Conditions	Relationship to child
Asthma	
Death – Unexpected, before the age of 50	
Diabetes	
Genetic Disorders	
Heart Disease	
High Blood Pressure	
Mental Illness	
Seasonal Allergies	
Seizures	
School Problems	
Miscellaneous	