PEDIATRIC SURGERY ASSOCIATES OF CLEAR LAKE

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Child's Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Mother/Guardian:	**Father/Guardian:**

Family doctor (or referring physician):

KNOWN ALLERGIES (Food OR Medications, please also list reactions):

Are the child's vaccinations up to date? _____ YES _____ NO
If no, please list which are not and why: _____

BIRTH HISTORY

Birth weight: _____ Was child born full term (40 weeks)? __YES __ NO If "NO", how many weeks early? _____

(Circle one) Was child a C-Section or Vaginal delivery? If C-Section, why?

List any previously diagnosed medical problems (if so, list by whom)

PLEASE CHECK "YES" OR "NO" FOR PAST AND PRESENT MEDICAL HISTORY

Has your child had any recent fever or weight loss? **If yes, please explain _____**	☐ **Yes**	☐ **No**
Does your child have any eye problems? **If yes, please explain _____**	☐ **Yes**	☐ **No**
Does your child have any ear, nose or throat problems? **If yes, please explain _____**	☐ **Yes**	☐ **No**
Does your child have any respiratory problems? **If yes, please explain _____**	☐ **Yes**	☐ **No**
Does your child have any heart problems? **If yes, please explain _____**	☐ **Yes**	☐ **No**
Does your child have any stomach or bowel problems? **If yes, please explain _____**	☐ **Yes**	☐ **No**
Does your child have any bone or join problems? **If yes, please explain _____**	☐ **Yes**	☐ **No**
Does your child have any nerve problems? **If yes, please explain _____**	☐ **Yes**	☐ **No**
Does your child have any skin disorders or problems? **If yes, please explain _____**	☐ **Yes**	☐ **No**
Does your child have any bone or bleeding disorders or problems? **If yes, please explain _____**	☐ **Yes**	☐ **No**
Does your child have any endocrine problems? **If yes, please explain _____**	☐ **Yes**	☐ **No**
Does your child have any emotional or developmental problems/disorders? **If yes, please explain _____**	☐ **Yes**	☐ **No**
Does your child have any OTHER medical problems not listed? **If yes, please explain _____**	☐ **Yes**	☐ **No**
Has your child ever been HOSPITALIZED? **If yes, please explain _____**	☐ **Yes**	☐ **No**
Has your child ever had any prior SURGERIES? **If yes, please explain _____**	☐ **Yes**	☐ **No**

SOCIAL HISTORY

Who is the LEGAL Guardian/Parent(s) of this child? _____
Relationship(s) to child_____

Is the child adopted or in foster care?	☐ **Yes**	☐ **No**
Are there pets in the home? **If yes, please list _____**	☐ **Yes**	☐ **No**
Does anyone in the house smoke? **If yes, who and how often? _____**	☐ **Yes**	☐ **No**

Type of home: APARTMENT _____ HOUSE_____ MOBILE HOME_____ OTHER_____

_____ (physician initials)

List the child's prescribed drugs and over-the-counter drugs (if "none" leave blank)		
Name	**Strength**	**Frequency Taken**

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	☐ M ☐ F	
Mother				☐ M ☐ F	
Siblings	☐ M ☐ F		Grandmother *Maternal*		
	☐ M ☐ F		Grandfather *Maternal*		
	☐ M ☐ F		Grandmother *Paternal*		
	☐ M ☐ F		Grandfather *Paternal*		

Any family members with bleeding disorders? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with anesthesia problems? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with kidney problems? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with heart disease? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with thyroid disease or problems? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with diabetes? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with cancer? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with lung/respiratory problems? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with gastrointestinal disease? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with musculoskeletal, bone, or joint disease? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No
Any family members with psychiatric disorders? If yes, type of disorder and relation to child:_____	☐ Yes	☐ No

_____ _____

Signature of person completing this form/relationship to patient Date Reviewed by provider Date