Medical History Questionnaire – AGE 5-17

Names of parents:_____
Marital status of parents:_____
Child adopted or in foster care? ☐No ☐Yes
(describe):_____
Siblings (names and ages):_____
_____

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Others living in home:_____
School:_____ **Grade level:**_____
Sports:_____**Other interests:**_____
Smokers in household? ☐No ☐Yes

Medications:_____
_____
Vitamins:_____
Medicine allergies (Specify reaction):_____
_____
Are immunizations up to date? ☐No ☐Yes
Name, city, state of prior health provider:
_____

Family history (specify WHICH family member and AGE of diagnosis):
Birth defects:_____
Diabetes:_____
Congenital heart disease:_____
Sudden cardiac death:_____
Childhood cancer (specify type):_____
Other serious childhood illnesses: _____
_____

PERSONAL HEALTH HISTORY **Please indicate if your child has a history of any of the following:**

Skin
☐ Acne
☐ Cold sores
☐ Eczema

Mental Health
☐ Anxiety
☐ Depression
☐ Attention Deficit (ADD)

Eye, Ear, Nose, Throat
☐ Visual impairment
☐ Strabismus (lazy eye)
☐ Hearing loss
☐ Ear infections, frequent
☐ Dental or gum disease

Respiratory
☐ Asthma
☐ Pneumonia

Allergy, Immune
☐ Seasonal or environmental allergies
☐ Other allergies (specify):_____
☐ Anaphylaxis
☐ Urticaria (hives), frequent
☐ Varicella infection (Chicken pox)

Heart, Vascular, Endocrine
☐ Congenital heart disease or surgery
☐ Diabetes

Gastrointestinal
☐ Reflux disease (GERD)
☐ Constipation, frequent

Genitourinary
☐ Urinary tract infections, frequent
☐ Yeast infections, frequent

Musculoskeletal
☐ Broken bones (specify locations):_____
_____

Neurological
☐ Seizures or epilepsy
☐ Headaches
☐ Head injury (specify age):_____

Developmental
☐ Autism or Asperger's syndrome
☐ Growth delay
☐ Speech delay
☐ Reading problems/ dyslexia

OTHER ILLNESSES: _____
_____
_____
_____

SURGERIES (include age): _____
_____
_____