

## FAMILY HEALTH SCREENING

NAME _____	AGE _____	DATE _____		
MEDICAL CONDITIONS	HAS CHILD HAD?	*CHILD'S FAMILY?	WHO?	
NERVE OR MUSCLE DISORDERS	YES NO	YES NO		
BROKEN BONES	YES NO	YES NO		
BONE DISEASES	YES NO	YES NO		
BIRTH DEFECTS	YES NO	YES NO		
FREQUENT EAR INFECTIONS	YES NO	YES NO		
CYSTIC FIBROSIS	YES NO	YES NO		
CROUP	YES NO	YES NO		
MUMPS, MEASLES, CHICKEN POX	YES NO	YES NO		
WHEEZING/ ASTHMA	YES NO	YES NO		
PNEUMONIA	YES NO	YES NO		
EYE PROBLEMS/ POOR VISION	YES NO	YES NO		
DENTAL PROBLEMS	YES NO	YES NO		
HEARING PROBLEMS	YES NO	YES NO		
HAY FEVER/ ALLERGIES	YES NO	YES NO		
ECZEMA/ SKIN PROBLEMS	YES NO	YES NO		
ANEMIA/ BLOOD PROBLEMS/ EASY BLEEDING	YES NO	YES NO		
ARTHRITIS	YES NO	YES NO		
ULCERS/ STOMACH PROBLEMS	YES NO	YES NO		
BLOOD TRANSFUSIONS	YES NO	YES NO		
DIARRHEA/ CONSTIPATION	YES NO	YES NO		
HEART ATTACK BEFORE AGED 55 YEARS	YES NO	YES NO		
LEARNING DISORDERS/ SCHOOL PROBLEM	YES NO	YES NO		
MENTAL RETARDATION	YES NO	YES NO		
KIDNEY/ BLADDER PROBLEMS/ BEDWETTING	YES NO	YES NO		
DIABETES	YES NO	YES NO		
SEIZURES/ CONVULSIONS	YES NO	YES NO		
HEART DISEASE/ ABNORMAL HEART RHYTHMS AS A CHILD OR TEENAGER	YES NO	YES NO		
HIGH BLOOD PRESSURE	YES NO	YES NO		
HIGH CHOLESTEROL	YES NO	YES NO		
LUNG DISEASE/ TUBERCULOSIS	YES NO	YES NO		
SEXUALLY TRANSMITTED DISEASES/ HIV	YES NO	YES NO		
MENTAL/ EMOTIONAL DISORDERS	YES NO	YES NO		
THYROID DISEASE	YES NO	YES NO		
CHILDHOOD CANCER	YES NO	YES NO		
MIGRAINES/ HEADACHES	YES NO	YES NO		
MONO/ HEPATITIS/ LIVER PROBLEMS	YES NO	YES NO		
SMOKE OR USE TOBACCO	YES NO	YES NO		
CONSUME ALCOHOLIC BEVERAGES	YES NO	YES NO		
USE RECREATIONAL DRUGS	YES NO	YES NO		
DEATH OF ANY SIBLING	YES NO	YES NO		
SIDS/ APNEA	YES NO	YES NO		
FREQUENT TONSILLITIS/ SINUSITIS	YES NO	YES NO		
ADENOID PROBLEMS	YES NO	YES NO		
LUPUS/ AUTOIMMUNE DISORDERS	YES NO	YES NO		
SLEEP PROBLEMS. SNORING	YES NO	YES NO		

\* FAMILY INCLUDES GRANDPARENT, MOTHER, FATHER, SIBLINGS, CHILDREN.

# HEALTH HISTORY QUESTIONNAIRE

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ CITY OF BIRTH \_\_\_\_\_  
HOSPITAL OF BIRTH \_\_\_\_\_ OBSTETRICIAN \_\_\_\_\_ CURRENT PHYSICIAN \_\_\_\_\_

## PREGNANCY:

ANY ILLNESSES? \_\_\_\_\_ ANY MEDICINES? \_\_\_\_\_  
DID YOU SMOKE? \_\_\_\_\_ USE ALCOHOL? \_\_\_\_\_ USE RECREATIONAL DRUGS? \_\_\_\_\_  
WAS BABY EARLY OR LATE? \_\_\_\_\_ C-SECTION? \_\_\_\_\_ ANESTHESIA? \_\_\_\_\_  
ANY OTHER PROBLEMS: \_\_\_\_\_

## PERINATAL:

BIRTHWEIGHT \_\_\_\_\_ DID BABY CRY RIGHT AWAY? \_\_\_\_\_ APGARS \_\_\_\_\_  
REQUIRE OXYGEN? \_\_\_\_\_ IV? \_\_\_\_\_ WAS BABY JAUNDICED (YELLOW)? \_\_\_\_\_  
DAYS IN HOSPITAL: \_\_\_\_\_ IF BREAST FED, HOW LONG? \_\_\_\_\_ IF BOTTLE FED, WHAT FORMULA? \_\_\_\_\_  
SINCE BIRTH, LIST ANY OF THE FOLLOWING THAT APPLY, INCLUDING DATES:

ILLNESSES \_\_\_\_\_  
\_\_\_\_\_

HOSPITALIZATIONS \_\_\_\_\_

SURGERIES \_\_\_\_\_

CHICKEN POX \_\_\_\_\_ MEASLES \_\_\_\_\_ MUMPS \_\_\_\_\_ OTHER \_\_\_\_\_

ALLERGIES OR REACTIONS TO MEDICATIONS \_\_\_\_\_

MEDICINES NOW TAKING \_\_\_\_\_

## IMMUNIZATIONS:

PLEASE GIVE THE RECEPTIONIST A COPY OF THE PATIENT'S IMMUNIZATION RECORD SO WE MAY HAVE A COPY FOR THE RECORD.

## SCHOOL:

CURRENT GRADE \_\_\_\_\_ SPECIAL EDUCATION? \_\_\_\_\_ NAME OF SCHOOL \_\_\_\_\_

USUAL GRADES: A-B B-C C-D D-F ANY PROBLEMS? \_\_\_\_\_

NUMBER OF SCHOOL DAYS MISSED THIS YEAR \_\_\_\_\_

MOTHER'S EDUCATION LEVEL \_\_\_\_\_ FATHER'S EDUCATION LEVEL \_\_\_\_\_

## LIST THOSE WHO CURRENTLY LIVE IN THE HOME, THEIR DATE OF BIRTH, AND HEALTH STATUS:

1. _____	DOB: _____	Health: _____
2. _____	DOB: _____	Health: _____
3. _____	DOB: _____	Health: _____
4. _____	DOB: _____	Health: _____
5. _____	DOB: _____	Health: _____
6. _____	DOB: _____	Health: _____
7. _____	DOB: _____	Health: _____

## OTHER:

DOES YOUR CHILD GO TO A SITTER? \_\_\_\_\_ DAYCARE? \_\_\_\_\_ PRESCHOOL? \_\_\_\_\_

IF YES, WHERE? \_\_\_\_\_