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 QUESTIONAIRE

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? _____