Patient's Name_____ **Health History Form** Today's Date_____

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

Family History

List family members that have any of the following conditions (siblings, parents, grandparents, aunts/uncles – indicate maternal or paternal):

ADHD:	High Cholesterol:
Anxiety:	Hypertension:
Asthma:	Immunodeficiency:
Blood Disorders:	Intellectual Disability:
Cancer:	Kidney Disease:
Depression:	Liver Disease:
Developmental Delay:	Seasonal Allergies:
Diabetes:	Seizures:
Eczema	Speech Problems:
Food Allergy:	Stroke:
Genetic Disorders:	Substance Abuse:
Hearing Loss:	Tuberculosis:
Heart Disease:	Other:

Social History

- What kind of diet does your child eat? Regular___ Vegetarian ___ Vegan ___ Gluten Free ___ Other _____
- Caffeine Intake: None___ Occasional___ Moderate___ Heavy___
- Exercise Level: None___ Occasional___ Moderate___ Heavy___
- What sports does your child play? _____
- Parents marital status: Married___ Unmarried___ Separated___ Divorced___ Widowed___
- Who does the child live with? Both parents___ Mother___ Father___ Relatives___ Adoptive parents___ Other_____
- Siblings? _____
- Childcare: None___ Relative___ Private sitter___ Daycare/Preschool___
- Animals at home? _____
- Does anyone in the family use tobacco products? Y___ N___
    a. Type: Cigarettes___ Vaping/E-cigarettes___ Smokeless tobacco___
- Smoke/CO detectors in the home? Y___ N___ Seat belt/Car seat used routinely? Y___ N___
- Sunscreen used routinely? Y___ N___ Insect repellent used routinely? Y___ N___
- Any guns in the home? Y___ N___ If so, are they locked? Y___ N___
- Year in school: _____ School name:_____
- Fluoride Status of home water: Fluoridated___ Non-fluoridated___ Unknown___
- Pool exposure? Y___ N___ Does your child wear a bicycle helmet? Y___ N___ NA___
- Any issues with bullying at school? Y___ N___
- Any recent changes in your family or social situation Y___ N___
- Does your family ever have difficulty making ends meet at the end of the month? Y___ N___
- Has your family moved frequently or lived with others due to finances within the last year? Y___ N___
- Do you have any concerns about meeting basic needs (food, housing, utilities, etc.)? Y___ N___
- Explain any "yes" answers _____

  _____

Surgical History

Please list any surgeries your child has had (e.g. tonsillectomy, appendectomy, ear tubes) with approximate dates:

_____

_____

_____

_____

_____

Past Medical History

Please note if your child has had any of the following conditions:

ADHD: Note:	Y___	N___	Developmental/Behavioral Disorders: Note:	Y___	N___
Allergies/Hay Fever: Note:	Y___	N___	Diabetes: Note:	Y___	N___
Anemia: Note:	Y___	N___	Difficulty Swallowing: Note:	Y___	N___
Anxiety Disorder: Note:	Y___	N___	Ear or Hearing Problem Note:	Y___	N___
Asthma: Note:	Y___	N___	Head Injury/Concussion: Note:	Y___	N___
Autism: Note:	Y___	N___	Headaches: Note:	Y___	N___
Bedwetting: Note:	Y___	N___	Heart Problems: Note:	Y___	N___
Bladder or Kidney Problem: Note:	Y___	N___	Hospital Stay: Note:	Y___	N___
Blood Disease: Note:	Y___	N___	Mental Illness: Note:	Y___	N___
Cancer: Note:	Y___	N___	Muscle, Joint, or Bone Problem: Note:	Y___	N___
Chicken Pox: Note:	Y___	N___	Seizures/Epilepsy: Note:	Y___	N___
Chronic Ear Infections: Note:	Y___	N___	Skin Problems: Note:	Y___	N___
Congenital Anomalies: Note:	Y___	N___	Thyroid Problems: Note:	Y___	N___
Constipation: Note:	Y___	N___	Vision or Eye Problems: Note:	Y___	N___
Depression: Note:	Y___	N___	Other Condition Not Listed: Note:	Y___	N___