Health Questionaire

Newborns thru Adolescents (18yrs)

Name: _____ Date: _____

Birthdate: _____ PCP: _____

Please always bring your Child's Vaccine Record to all Physicals and Well Child checks

For ***Established Patients*** , please review and **only** note any ***changes*** since you last completed our form.

Medications

Please list any medications that you currently take regularly (including non-prescription medications, vitamins, or supplements) and the Strength and Dosing;(If prescribed by someone other than Irvine Family Care, please list that doctor's name)

Allergies

Please list any allergies to medications, foods or other, and the kind of reaction you had to each, and your age at the time

Birth History:

_____ Mother's Habits during pregnancy: Any drug / smoking / or alcohol use;**Yes/ No** *type* : _____

_____ Any complications during the pregnancy or delivery?**Yes/ No** What kind: _____

_____ Birth Weight

_____ Term or Premature if premature, how many weeks: _____

_____ Any complications during first days of life? **Yes/ No** What kind: _____

Illnesses/Conditions

Do you have or have you ever had any of the following:

Note type of/ kind of: Age diagnosised

_____ Anemia _____
_____ Anxiety /Panic Attacks/ Phobias _____
_____ Allergies _____
_____ Asthma _____
_____ Austism/Developemental Disorders _____
_____ Birth Defects _____
_____ Cancer: type: _____
_____ Colitis _____
_____ Concussion _____
_____ Constipation _____
_____ Depression / Suicidal thoughts _____
_____ Diabetes _____
_____ High Cholesterol _____
_____ Kidney Infection or Disease _____
_____ Heart Murmur type: _____
_____ Pneumonia _____
_____ Rheumatoid problems _____
_____ Seizure Disorder _____
_____ Sexually Transmitted Disease _____
_____ Speech Problems _____
_____ Thyroid Disorder _____

Surgical Procedures/Hospitalizations Year

If you know, note the name of surgeon

Boys: Circumcision: **Yes/ No**

_____ _____
_____ _____
_____ _____

Serious Injuries

_____ _____
_____ _____
_____ _____

Childhood Diseases	**Year**
_____ Chickenpox	_____
_____ Measles	_____
_____ Mumps	_____
_____ Polio	_____
_____ Other	_____

Gynecological History:Adolescent Girls Only

First Day of your Last menstrual period: _____

Are you pregnant? _____

At what age did you start having periods? _____

Have you ever had an abnormal Pap? _____

Have you ever had HPV? _____

Have you had the HPV vaccine? Date: / _____

Family History

Has any blood relative ever had any of the following : Note if **M** (mother's side) or **P** (paternal- father's side) and **Age**

Relative (mother, father, sister, aunt, grandmother etc.)	**Age**		Living Age	Deceased Age (at death) & cause
Anaesthesia Complications:				
Alcoholism/ Drug Abuse		Father		
Asthma / Allergies		Mother		
Cancer type?		Brother / Sister		
Diabetes				
High Cholestrol				
High Blood Pressure				
Mental Illness/Anxiety / Suicide				
Seizures/Neurological Diseases				
Birth Defects				
Other				

Continued on other side →

Health Quesionnaire continued Name: _____ Date: _____

Social History

Are your parents married? **Yes / No** Who do you live with? _____

How are things going at home? _____
Is there any fighting? **Yes / No**

Have you ever felt unsafe or abused, either physically or emotionally? **Yes / No** Currently? **Yes / No**
Are there any other kids, teachers, coaches or family members who are bothering you? **Yes / No**

How are things going at school? _____
Any scholastic problems? **Yes / No**
What are your favorite subjects? _____

Have you thought about the your future? **Yes/ No** If so, what are your current plans? _____

How is it going making friends? _____ Do you have someone you can confide in? **Yes / No**

Do you wear seat belts? **Yes / No** Are you using your car seat if you are under 60 lbs? **Yes / No**
Do you wear your bike helmet? **Yes/ No**
Do you wear the right protective gear for the activities you do? **Yes / No**
ex: rollerblading or skateboarding helmets and wrist guards?

What things do you like to do most? _____
Are you doing any sports or athletics or dance? What type? _____
How often? _____

How much TV do you watch in a day on average? _____
How much time do you spend on gameboys, video games, computer games? _____

How do you feel about how your body is changing as you are growing? _____
Are you concerned about your weight? **Yes / No**
Have you achieved staying dry at night (not wetting the bed)? **Yes / No**
Are you having any nightmares or bad dreams? **Yes / No**

Are you trying to eat low fat foods? **Yes/ No**
Do you drink milk, or eat dairy products, like cheeses and yogurts? **Yes / No**
Do you eat 5 (five) fresh fruits and vegetables a day? **Yes/ No**

Adolescent Girls: How are your periods? _____ Any cramps? _____
Questions for kids 10 and older:
How are you feeling about your life? _____
Have you ever thought about hurting yourself or others, or running away, or suicide? **Yes / No**

Do you or have you ever smoked or chewed tobacco? **Yes / No**

Do you or have you ever used illegal drugs? **Yes/ No** *Type:* _____
Do you drink alcohol? **Yes / No** *What kind?* _____ *How much per week?* _____
Would you ever get into car with someone who has been drinking and is wanting to drive? **Yes / No** _____

Are you, or have you, or are you thinking about, being sexually active? _____
Any concerns or thoughts about your sexual identity? **Yes / No**
Do you need any information about contraception? **Yes / No**
Any other information? **Yes / No**