

BRISTOL PARK

MEDICAL GROUP

Health Questionnaire - Age 0-11

Patient's Name _____ Age _____ Date _____

Address _____ Phone _____

HISTORY OF PAST ILLNESS

Has this child/infant ever had:

- | | |
|---|---|
| measles <input type="checkbox"/> No <input type="checkbox"/> Yes | rheumatic fever or heart disease <input type="checkbox"/> No <input type="checkbox"/> Yes |
| mumps <input type="checkbox"/> No <input type="checkbox"/> Yes | tuberculosis <input type="checkbox"/> No <input type="checkbox"/> Yes |
| chickenpox <input type="checkbox"/> No <input type="checkbox"/> Yes | congenital abnormalities <input type="checkbox"/> No <input type="checkbox"/> Yes |
| diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes | other serious diseases <input type="checkbox"/> No <input type="checkbox"/> Yes |
| cancer <input type="checkbox"/> No <input type="checkbox"/> Yes | (please specify) _____ |

Has this child/infant ever:

- | | |
|--|--|
| been hospitalized <input type="checkbox"/> No <input type="checkbox"/> Yes
(please specify) _____ | had surgery <input type="checkbox"/> No <input type="checkbox"/> Yes
(please specify) _____ |
|--|--|

Has this child/infant ever:

- | | |
|---|--|
| had broken bones <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| had head concussions or injuries <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| been knocked unconscious <input type="checkbox"/> No <input type="checkbox"/> Yes | |

Does this child/infant have:

- | | |
|--|--|
| any allergies / sensitivities <input type="checkbox"/> No <input type="checkbox"/> Yes
please specify (food, drugs, etc.) _____ | |
|--|--|

FAMILY HISTORY:	If Living:		If Deceased		Has any blood relative ever had:
	Age	Health	Age (at death) & Cause		
Father					Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes
Mother					Tuberculosis <input type="checkbox"/> No <input type="checkbox"/> Yes
Brother/Sister					Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes

1. Birthweight _____ Was this a premature birth? No Yes
2. Do you consider this child/infant's growth and development normal? No Yes
3. Do you feel this child/infant receives proper nutrition? No Yes
4. Do you think you have ever abused your child/infant before? No Yes
5. If in school, what grade? _____ Do you feel the progress is normal? No Yes
6. Any history of headaches? No Yes
7. Any history of stomach aches? No Yes
8. Any skin problems? No Yes
9. Is this infant/child on any medications? No Yes
(please specify) _____
10. Is this child/infant exposed to second-hand smoke in the home? No Yes
11. Do you think your child/infant is up to date on immunizations? No Yes
If you have the immunization record, please present it to the nurse.
12. Is there any other important history that the doctor needs to know? No Yes