Patient Label
Name: ____________________
DOB: ______________________
M#:_______________________

Pediatric Health History Questionnaire

Patient Name:_________________________ Date of Birth:________________________

Primary Care Provider:____

Dentist:___________________________ Last dental visit:____________________________________

List all medications, vitamins, and over the counter medications you are taking.

Medication	Dose	How often you take it

Please list any allergies and reaction:

Allergy	Reaction

Preferred Pharmacy:

1st Choice:__________________________ 2nd Choice:_________________________

Social History:

Patient resides with	Is anyone in the home a tobacco user?
Primary:____________________________ **Secondary:**_________________________	Yes No

Childcare Provider (circle all that apply)				
Mother #days/wk	Father #days/wk	Grandparents #days/wk	Daycare #days/wk	Sitter #days/wk

Please Fill Out Back Page

Please circle answers to the questions below			
Uses a bike/skating helmet? Y or N	**Firearms in the home?** Y or N	**Type of water:** City Well	**Home Built before 1978?** Y or N

Parent Marital Status

Married Divorced Partner Widowed Single Remarried

Vehicle Restraint Type

Car seat-rear facing Car seat- front facing Booster Seat belt None

Education: School Name:____Grade Level:_____________________

Is your child (please circle one) At grade level Below grade level Above grade level

Patient Medical/Surgical History: please list all past medical history and what year it occurred.

Medical Diagnosis	**Year**	**Comments**
Surgery	**Year**	**Comments**

Family History:

List grandparents, mother, father, sisters, and brothers:

Alcoholism
Alzheimer's
Bleeding disorders
Blood clots
Cancer/Type
Depression, Bi-Polar
Diabetes
Heart attack/disease
High Cholesterol
High Blood Pressure
Other Mental Illness
Other Substance Abuse
Stroke
Thyroid
Alive and Well

Thank you for taking the time to complete this form.