CHILD HISTORY QUESTIONNAIRE

Name_____DOB_____Age_____ Gender_____

Parent/legal guardian:_____
Mother's name:_____Phone:_____
Father's name:_____ Phone:_____

Birth History:
Delivery: Vaginal_____ C-section_____ Full-term: yes_____ no_____
If no, premature at_____months Birthweight:_____ Length_____

Family history:
Mother's age_____ Health problems?_____
Father's age_____ Health problems?_____

Siblings: List their age, gender, and health problems if any
1._____
2._____
3._____
4._____
5._____

Child medical history:
Hospitalizations: List reasons and approx dates _____
_____
Surgeries: List reasons and approx dates_____
_____
Allergies: include drug and environmental/food_____
_____
Chronic medical conditions/other childhood illnesses/ congenital conditions_____
_____
_____
Breast-fed or formula?_____
Any other concerns you would like us to know?_____
_____

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Medications: List names and dosages, include OTC:_____

_____

_____

Is your child up-to-date on immunizations? _____

Please bring immunization record to visits

Parent/guardian signature_____ **Date**_____

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