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CHILD HEALTH QUESTIONNAIRE

Child's Name_____Date_____Sex_____DOB_____

Please respond to the following questions so that we can get to know your child better.

Birth History
Birth Weight?_____
Length of pregnancy?_____
During pregnancy was there:
Any illness or problem?
_____
_____
_____
_____
Any medicine, hormone, or drug taken?
_____
_____
_____
Infection?_____
Injury/Accident?_____
Surgery?_____
Bleeding?_____
High Blood Pressure?_____
High Blood Sugar/Diabetes?____
Duration of Labor_____hours
Was baby born breech?_____
Hip ultrasound normal?_____
Was baby born by Cesarean?____
Delayed breathing?_____
In the nursery, was your baby
On oxygen?_____
In an incubator?_____
If yes, hours_____or days_____

Infancy
In first 4 wks of life did baby have:
Infection?_____
Yellow jaundice? _____
Blood transfusion? _____
Convulsion?_____
Feeding in Infancy:
Breast___How long?_____
Formula_____How long?_____
Spitting/reflux?_____
Colic?_____

Growth/Development (age)
Sat alone_____
Walked_____
4 to 6 words_____
2-word sentences_____
Weaned to cup_____
Speech problem_____
First period_____
Learning or school problems
_____
_____
_____

Hospitalizations (age)
_____
_____
_____
_____

Surgery and Injuries (age)
Circumcision?_____
Tonsils/Adenoid Removal?_____
Appendix Removal?_____
Ear tubes?_____
Eye surgery?_____
Other operations?_____
Broken bones?_____

Illnesses (age)
Whooping cough (pertussis)?____
Chickenpox?_____
Frequent ear infections?_____
More than 6 colds in a year?_____
Frequent tonsillitis?_____
Pneumonia?_____
Chronic diarrhea?_____
Kidney or bladder infection?_____

Other Problems (age)

Bedwetting after age 6?_____
Trouble hearing?_____
Heart murmur/problem?_____
Chronic constipation?_____
Frequent Urination?_____
Weakness of arms or legs?_____
Inability to get to sleep?_____
Convulsions?_____
Has your child ever been:
Unconscious from injury?_____
Treated for poisoning?_____
Other/More details:
_____
_____
_____
_____

Medications
Medications/vitamins/supplements taken on a daily basis
_____
_____
_____
_____
To your knowledge, has your child received all recommended immunizations?_____

Emotion and Behavior (age)
Serious family conflicts/problems?
_____
_____
Depression/anxiety?
_____
_____
Problems with drugs/alcohol/tobacco?
_____
_____
Has your child seen a therapist?
_____
_____

Allergies (age)
Does your child have:
Hives?_____
Eczema?_____
Hay fever/Allergic Rhinitis?_____
Asthma?_____
Please list any allergies to:
Medications
_____
_____
Foods
_____
_____
Environment
_____
_____
Is there anything else we should know about your child?
_____
_____
_____