HEALTH QUESTIONNAIRE AGES 0 – 11

Patient's Name:	Sex:	Date of Birth:
Address:	Phone:	

HISTORY OF PAST ILLNESS:
Has this child/infant ever had:

measles	☐ No ☐ Yes	rheumatic fever or heart disease	☐ No ☐ Yes
mumps	☐ No ☐ Yes	tuberculosis	☐ No ☐ Yes
chickenpox	☐ No ☐ Yes	congenital abnormalities	☐ No ☐ Yes
diabetes	☐ No ☐ Yes	other serious diseases	☐ No ☐ Yes
cancer	☐ No ☐ Yes	(please specify):	☐ No ☐ Yes

Has this child/infant ever:

been hospitalized:	☐ No ☐ Yes	had surgery:	☐ No ☐ Yes
(please specify):		(please specify):	

Has this child/infant ever:

had broken bones:	☐ No ☐ Yes
been knocked unconscious:	☐ No ☐ Yes
had head concussions or injuries:	☐ No ☐ Yes

Does this child/infant have:

any allergies / sensitivites:	☐ No ☐ Yes
please specify(food, drugs, animals, etc.):	

FAMILY HISTORY:

	If Living		If Deceased	
	Age	Health	Age at death	Cause of death
Father				
Mother				
Brother / Sister				

Birth weight:	Was this a premature birth?	☐ No ☐ Yes
Do you consider this child's/infant's growth and development normal?		☐ No ☐ Yes
Do you feel this child/infant receives proper nutrition?		☐ No ☐ Yes
Has this child/infant ever been abused?		☐ No ☐ Yes
If in school, what grade:	Do you feel the progress in school in normal?	☐ No ☐ Yes
Any history of headaches?		☐ No ☐ Yes
Any history of stomach aches?		☐ No ☐ Yes
Any skin problems?		☐ No ☐ Yes
Is this child/infant on any medications?		☐ No ☐ Yes
Please specify:		
Is this child/infant exposed to second-hand smoke on a regular basis?		☐ No ☐ Yes
Is this child/infant up to date on immunizations?		☐ No ☐ Yes
If you have a record of immunizations, please give it to the doctor or nurse.		
Is there any other important history the doctor needs to know?		☐ No ☐ Yes
Please specify:		