



Canby Healthcare Clinic

Name: _____

Date of Birth: _____

CHILDREN'S HEALTH QUESTIONNAIRE

Please provide information which will help us construct a more complete health record for your child.

Complete as much of the form as is appropriate for your child.

EARLY HISTORY

Birthplace: _____ Birth Weight: _____

List any major problems during pregnancy (infection, premature labor, diabetes, drugs or alcohol):

List any major problems with delivery or birth (C-section, trouble breathing, Breech presentation, etc.):

List any major problems during the first few months of life (jaundice, infections, feeding problems, etc.):

Was your child breastfed and if so for how long? _____

MEDICAL HISTORY

List any chronic or recurrent medical problems and surgeries your child has experienced (asthma, allergies, ear infections, constipation, growth problems, etc.): _____

List any medication your child takes regularly: _____

List your child's previous physician and clinic name: _____

List any major injuries or trauma your child has experienced (broken bones, concussions, etc.): _____

List the year and the reason for any overnight (or longer) hospital stays for your child: _____

List any allergies (food, medications): _____

(CONTINUE ON BACK)

FAMILY HISTORY: List any history of inheritable disease or other health problems from blood relatives.

	Asthma	Cancer	Diabetes	Cholesterol & High Blood Pressure	Stroke & Heart Disease	Migraine	Thyroid	Psychiatric or ADHD
Mother								
Father								
Sister								
Brother								
Grandparent								
Other								

Any other pertinent familial health problems: _____

IMMUNIZATIONS: It is always important to know your child's immunizations status, regardless of age. Please indicate below whether you believe your child's immunizations are current. If you have a copy of their immunization record, please provide a copy for their chart.

Immunizations current: _____ Not current: _____

SOCIAL HISTORY

Parent Name: _____ Occupation: _____

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List the names and ages of all of the people living in your child's primary residence:

Who cares for your child during the day? _____

Does anyone at home smoke? _____ Are there any guns in your child's home? _____

School progress, if applicable:
 Academic: _____
 Social: _____
 Athletic: _____

Any recent significant changes in the child's home, school, or social situation that may be affecting them?

ADDITIONAL CONCERNS/COMMENTS: _____

