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.): ______________________________

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List any medication your child takes regularly: ____

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____

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

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

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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: ______________________________

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