Dacula Pediatrics

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Initial Health History Questionnaire

Today's Date: _____

Name of Patient: _____

Date of Birth (MM/DD/YYYY): ____/____/____ Sex (Circle): Male/Female

Allergies: _____ Medications: _____

Other: _____

Birth History:

Prenatal Delivery (Circle): Yes/No Weeks of Gestation:_____ Birth Weight:_____

Problems at Birth: _____

Any Hospitalizations: _____

Any Surgeries: _____

Other Concerns: _____

Immunizations Up to Date? (Circle): Yes/No/Unsure

Biological Family History: Check if there is a family history of the condition and list who is affected

- ❑ Childhood hearing loss_____
- ❑ Nasal Allergies_____
- ❑ Asthma_____
- ❑ Tuberculosis_____
- ❑ High blood pressure (before 50)_____
- ❑ High cholesterol_____
- ❑ Anemia_____
- ❑ Bleeding disorder_____
- ❑ Liver disease_____
- ❑ Cancer (before 55)_____
- ❑ Kidney Disease_____
- ❑ Diabetes (before 50)_____
- ❑ Drug abuse_____
- ❑ Mental illness_____
- ❑ Mental retadation_____
- ❑ Immune problems, HIV, AIDS_____
- ❑ Dental decay_____
- ❑ Additional family history_____

_____

_____

Form completed by: _____ Relationship to parent: _____

Signature: _____ Date: _____