Northern Nevada MEDICAL GROUP

CHILD HEALTH QUESTIONNAIRE

Patient Name: _____

Patient Date of Birth: _____ Today's Date: _____

School Grade: _____ Name of School: _____

What would you like to talk to your child's doctor about today?

_____

MEDICATIONS

Patient Pharmacy: _____

Please list <u>all</u> medications, including over the counter medications, prescriptions medications, and vitamin supplements (Or attach complete medication list)

Medication Name and Strength/Frequency

_____ _____

_____ _____

_____ _____

ALLERGIES

Please list all medication, environmental, and food allergies

Allergy and Reaction

_____ _____

_____ _____

_____ _____

MEDICAL HISTORY

Child's birth weight _____ lbs _____ oz

Were there any problems with the pregnancy, labor or delivery? ..... ☐Yes ☐No

If yes, please explain: _____

Please list any surgeries or hospital stays your child has had and their approximate date/year

Type of surgery / reason for hospitalization *Date*

_____ _____

_____ _____

_____ _____

_____ _____

Has your child ever had a repeated or complicated illness? ..... ☐Yes ☐No

If yes, please explain: _____

Is your child currently receiving care from any other doctors, dentists, or other health care professionals? If yes, we would like to know whom so that we can we can coordinate their care:

_____

Provider's Name *Condition they are treating your child for*

_____ _____

_____ _____

_____ _____

_____ _____

Is your child up to date on immunizations? …….…… ☐Yes ☐No

Family History

Family at home

Name	*Relationship*	*Age*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Birth parents if other than above

Name	*Age*
_____	_____
_____	_____

Check any of the diseases that run in your family and please note who had it:

	None	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other: Please Explain
Alcoholism or Drug Use										
Anemia										
Asthma										
Birth Defects										
Cancer(Indicate Type)										
Diabetes										
Mental Illness										
Sickle Cell Disease										
Other: Please Explain										

Social History

Does anyone in the home smoke or use tobacco products? …… ☐ Yes ☐ No

Do you have a car seat for your child? ..... ☐ Yes ☐ No

What type? _____

Forward or rear facing? _____

Are there guns in the home? …… ☐ Yes ☐ No

If yes, are they kept in a locked location? _____

Are there functional smoke detectors in the home? …… ☐ Yes ☐ No

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

Parent/Guardian Signature: _____ Date: _____