CHILD/ADOLESCENT HEALTH HISTORY AND LIFESTYLE QUESTIONNAIRE

Today's Date ____________________

Child's Name ______________________________ **Date of Birth** _____/_____/_____ **Age** ______

Health history details are crucial to consider as plans are made for your child's treatment. All information provided here is confidential.

PRIMARY CARE

Pediatrician ____________________________________ **Date of last full physical exam** ____/____ *(month/year)*

How often does your child get: physical exams? ________________ **dental exams?** _____________

Date of last pediatrician visit _____/_____ *(month/year)* **Reason for last visit** ______________________________

Date of last full eye exam __________________ **Date of last full hearing exam** ________________

Has your child had a tonsilectomy? ☐ Yes ☐ No **adenoidectomy?** ☐ Yes ☐ No

Medication allergies 1 ____________________ 2 ____________________ 3 ______________________

Others medications with unfavorable reactions or side effects ______________________________________

Environmental allergies ____

Food allergies ____

Bowel Habits: Approximately how often? ______________________________________

Check all that apply and explain in space below: ☐ Constipation ☐ Diarrhea ☐ Accidents

Explain ____

Urination Habits: Approximately how many times per day? __________________________

Check all that apply and explain: ☐ Night accidents ☐ Day accidents ☐ Difficulty starting urine stream

Explain ____

Please rate your child's overall health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Blood Pressure________ **Heart Rate**________ **Weight: (lbs)**________

What was your child's weight and height <u>one year ago</u>? ____________________________________

MEDICATIONS

List all prescription medications and over-the-counter supplements or vitamins your child currently takes, even if only once in a while. Include <u>strength, dosage</u> and <u>frequency</u>.

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Does your child have difficulty swallowing pills? ☐ No ☐ Yes (Describe) ____________________________

Affinity Staff Notes ____

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