HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your child's health care provider better understand your child's medical concerns and conditions. If you cannot remember specific details, please approximate. Add any notes you think are important. **ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.**

Main reason for today's visit: _____ Other concerns: _____

PHARMACIES - list the address & phone number for pharmacies, both local and mail away.
1.
2.

YOUR CHILD'S PROVIDERS - Please list the doctors your child sees in the community.
1.
2.

CHRONIC CONDITIONS (list any additional on the back)
1.
2.

MEDICATION/ALLERGY SENSITIVITY
List all medications your child is allergic to and their reaction: (list any additional on the back) □ None

ALLERGY:	**REACTION:**
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PAST MEDICAL HISTORY - Please check the box if your child has had or experienced these symptoms or medical issues. If none, indicate by checking the "none" box to the right. □None

□ ADD or ADHD	□ Congenital Anomalies	□ Hospital Admission other than birth
□ Allergies	□ Constipation	□ Muscle, Joint or Bone Problems
□ Anemia	□ Depression	□ Seizures/Epilepsy
□ Asthma	□ Developmental or Behavioral Disorders	□ Serious Illness or Injuries
□ Bedwetting	□ Diabetes	□ Skin Problems
□ Bladder or Kidney Problems	□ Ear or Hearing Problems	□ Thyroid Problems
□ Blood Diseases	□ Eczema, Hives, or other skin conditions	□ Vision or Eye Problems
□ Cancer	□ Headaches / Migraines	□ Other:
□ Chicken Pox	□ Heart Problems	□ Other:

SURGICAL PROCEDURES □ More than two (list any additional on the back) □ None

Month / Day / Year	Procedure / Operation	Complication (Y/N)
1.		
2.		

To my understanding, this represents an accurate portrayal of my child's health history. I will inform Apple-a-Day Pediatrics as changes or updates occur.

Patient Representative Signature Relationship Date