Abundant Health Family Practice

6130 N. La Cholla Blvd Suite 240 ● Tucson AZ 85741
Office: 520-326-1457 ● Fax: 520-326-1464

Today' s Date:

PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Previous provider (Pediatrician):		**Date of last physical exam:**
Name(s) of parent(s):		**Name(s) of Guardian(s):**

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

_____

Immediate Concerns: _____

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have your child ever had a blood transfusion?	☐ Yes	☐ No

List prescribed and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Form Updated 07/2019 - CElliott

NAME_____ DATE_____

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Activity	☐ Sedentary (No exercise) ☐ Yes ☐ No					
	How much screen time does your child participate in daily (TV, video games)?					
	☐ Sports teams? ☐ Yes ☐ No How often does your child participate?					
	Hyperactivity? ☐ Yes ☐ No					
Diet	Is your child on a specific diet? ☐ Yes ☐ No				☐ Yes	☐ No
	If yes, is it a physician prescribed medical diet?				☐ Yes	☐ No
	Number of meals your child eats in an average day?					
	Sugar intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
	Protein intake	☐ Hi	☐ Med	☐ Low		
	Soda/Caffeine	☐ Hi	☐ Med	☐ Low		
Personal Safety	Are both parents in the home?				☐ Yes	☐ No
	Has your child been exposed to second hand smoke (smokers)?				☐ Yes	☐ No
	Does your child understand home safety?				☐ Yes	☐ No
	Does your child understand water safety?				☐ Yes	☐ No
	Does your child have any concern or confusion about sexual orientation?				☐ Yes	☐ No
	Do you have concerns about your child's safety with others?				☐ Yes	☐ No
	Is your child being bullied at school?				☐ Yes	☐ No
	Any additional concerns?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS	Age	SIGNIFICANT HEALTH PROBLEMS
Father			☐ M ☐ F	
Mother			☐ M ☐ F	
Sibling	☐ M ☐ F		☐ M ☐ F	
	☐ M ☐ F		☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*	
	☐ M		**Grandfather**	

Form Updated 07/2019 - CElliott

NAME_____ DATE_____

	☐ F		*Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

OTHER PROBLEMS

Check if your child has any symptoms in the following areas

☐ Visual Changes/Loss	☐ Asthma	☐ Over-eating
☐ Head Injury	☐ Heart Problems	☐ Childhood Illness - specify
☐ Headaches	☐ Constipation	☐ Tobacco use
☐ Seizures	☐ Diarrhea	☐ Alcohol use
☐ Hearing Loss	☐ Diabetes	☐ Other drug use
☐ Nose Problems	☐ Trouble sleeping	☐ Other chronic health issues - specify
☐ Throat Problems	☐ Attention issues	
☐ Thyroid disorder	☐ Depression or anxiety	
☐ Environmental Allergies	☐ Frequent crying	
☐ Shortness of breath	☐ Poor appetite	

GYNECOLOGICAL HISTORY (FEMALE PATIENTS ONLY)

Please discuss any additional concerns with the Provider

Last menstrual cycle (period) Date_____	Age cycle started _____	List any additional concerns:
Flow ☐ light ☐ moderate ☐ heavy	Monthly periods? ☐ Yes ☐ No	
Sexually active? ☐ Yes ☐ No	Days of flow per cycle (IE: 3-7) _____	
Using birth control? ☐ Yes ☐ No	Type of birth control:	
Any Pregnancies? ☐ Yes ☐ No	Frequency of cycle ex. 28-32 days apart _____	
Miscarriages _____ Abortions _____		
Your age at first delivery _____		

PROVIDER'S COMMENTS

Form Updated 07/2019 - CElliott

NAME_____ DATE_____

Form Updated 07/2019 - CElliott

NAME_____ DATE_____