Children's Health History Questionnaire

Patient's Name: _____ Date of Birth:_____

Parent/Guardian's Name(s): _____

Address: _____

Phone: _____ Email: _____

Pregnancy and Birth History

Mother's age at birth:	Father's age at birth:	Siblings:

Did Mother have any of the following during pregnancy?

☐ Tobacco Use (How Much)	☐ Alcohol Use (How Much)
☐ High Blood Pressure	☐ Drug Use (What Kind)
☐ Infections (Type and treatment)	☐ Medications (Prescription-Type)

Newborn History

Birth Weight:	Birth Length:	Head Circumference:
Delivery: ☐ Vaginal ☐ C-Section	Complications: ☐ **Yes** ☐ **No**	Gestational Age:

During the first week of life did the patient have any of the following?

☐ **Feeding Trouble**	☐ **Seizures**	☐ **Fever**
☐ **Excess Vomiting**	☐ **Breathing Troubles**	☐ **Receive(d) Antibiotics**
☐ **Jaundice (yellow skin)**	☐ **Need for Oxygen**	☐ **Diarrhea**
☐ **Cyanosis (blueness)**	☐ **Blood Transfusion**	☐ **NICU**

Medical History

Where has child gone for check ups previously:
Date of last medical check up:
Date of last dental check up:
Date of last eye check up:
Is the child up-to-date on immunizations? **Please supply immunization records**
Has your child ever been hospitalized or had any surgery? If yes, list age and reason:
Do you have any concerns about your child's development? If yes, please describe:
Medications: (please include frequency)
Female Patients: Age of menstruation _____ Menstrual Flow: ☐ Regular ☐ Irregular ☐ Pain/Cramps

Does your child have or had the following?

☐ **Chicken Pox**	☐ **Measles**	☐ **Mumps**
☐ **Ear Infections** (how many in the past year)	☐ **Sore Throats** (how many in the past year)	☐ **Bed Wetting** (how many times a week & month)
☐ **Heart Murmur**	☐ **Kidney/Bladder Infection**	☐ **Broken Bones**
☐ **Allergies**	☐ **Seizures**	☐ **Head Injury**
☐ **Diabetes**	☐ **Asthma**	☐ **Wears Glasses**
☐ **Speech Delay**	☐ **Hearing Impairment**	☐ **Cognitive Impairment**
☐ **ADHD**	☐ **Depression**	☐ **Autism**
☐ **Anemia**	☐ **Alcohol/Drug Concerns**	☐ **STDs/HIV**

Social History

Child lives with & relationship: _____

Anyone in the home smoke: _____

Family History

Please Check the Following if Parents, Siblings or Grandparents have the following:

☐ **Anemia**	☐ **Cancer**	☐ **Diabetes**
☐ **Heart Disease**	☐ **High Blood Pressure**	☐ **Kidney Problems**
☐ **Mental Illness**	☐ **Seizures**	☐ **Skin Problems**
☐ **Other**	☐ **Other**	☐ **Other**

Consent to Treat

I have the legal right to consent to medical and surgical care/treatment for this patient. I voluntarily authorize and consent to such medical care, treatment, and diagnostic tests that the clinic and its licensed medical providers and designees consider necessary. I understand that no warranty or guarantee has been or will be made as the result or cure from treatment. I understand that by signing this form, I am giving permission to Incredible Family Health & Wellness and its providers to administer treatment to this patient for as long as they are under the care of Incredible Family Health & Wellness or until I withdraw my consent.

Electronic Prescriptions (E-Prescribing)

I authorize E-prescribing for prescriptions. This allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispensing history as long as a provider/patient relationship exists.

Acknowledgements

I acknowledge that administrative data, demographics information and other health information describing patient care, services and outcomes are collected and used for healthcare operations, governmental and nongovernmental reporting, and comparisons with other providers. In some instances, performance data is aggregated and reported per physician. In every instance, we make every reasonable effort to maintain patient and provider anonymity.

Imaging

I consent to the taking of photographs or films related to the care and treatment and understand that such photographs of films may be made part of the medical record and/or used for internal purposes such as performance improvement or education.

Notice of Privacy Policies

I have had the opportunity to review the "Notice of Privacy Policies" detailing how my information may be used and disclosed as permitted under federal and state law. I further understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to these restrictions.

Immunization Policy

I acknowledge that I have been educated on the importance of immunizations. Incredible Family Health & Wellness follows the immunization guidelines recommended by the American Academy of Pediatrics and the CDC. For information about these vaccines and the diseases they protect please visit www.aap.org and www.cdc.gov. I understand that I have the right to choose or decline immunizations without any repercussion from Incredible Family Health & Wellness.

By Signing below, I agree that I am the responsible parent/guardian for the above named patient. I also agree that everything I have entered is correct to the best of my knowledge. I also acknowledge that I agree with the above policies and procedures.

Patients Name: _____

Parent/Guardian Name: _____

Signature: _____

Date: _____