Orion Family Health

| Dr Monica Bartoli, DO | | | | | | | | | | | | **Original Date:** | | | | |  | | | |
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| **Dates Revised:** | | | | |  | | | |
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| PEDS **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:** | | |  | | | | | | | |
| Parents Names: | |  | | | | | | | | | | | | | | | | | | |
| **Previous or referring doctor:** | | | | |  | | **Date of last physical exam:** | | | | | | | |  | | | | | |
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| **PERSONAL HEALTH HISTORY** | | | | | | | | | | | | | | | | | | | | |
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| **Childhood illness:** | | | ◻ Measles ◻ Mumps ◻ Rubella ◻ Chickenpox ◻ Rheumatic Fever ◻ Polio | | | | | | | | | | | | | | | | | |
| **Immunizations and dates:** | | | | ◻ Tetanus | |  | ◻ Pneumonia | | | |  | | | | | | | | | |
| ◻ Hepatitis | |  | ◻ Chickenpox | | | |  | | | | | | | | | |
| ◻ Influenza | |  | ◻ MMR *Measles, Mumps, Rubella* | | | | | | |  | | | | | | |
|  | | | | ◻ Shingles | |  | HPV | | | | | | |  | | | | | | |
|  | | | | ◻ COVID | |  | OTHER: | | | | | | |  | | | | | | |
| **List any medical problems that other doctors have diagnosed** | | | | | | | | | | | | | | | | | | | | |
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| **Surgeries** | | | | | | | | | | | | | | | | | | | | |
| Year | Reason | | | | | | | | Hospital | | | | | | | | | | | |
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| **Other hospitalizations** | | | | | | | | | | | | | | | | | | | | |
| Year | Reason | | | | | | | | Hospital | | | | | | | | | | | |
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| **List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers** | | | | | | | | | | | |
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| Name the Drug | | | Strength | | | Frequency Taken | | | | | |
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| **Allergies to medications** | | | | | | | | | | | |
| Name the Drug | | | Reaction You Had | | | | | | | | |
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| **HEALTH HABITS AND PERSONAL SAFETY** | | | | | | | | | | | |
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| ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL. | | | | | | | | | | | |
| **Exercise** | ◻ Sedentary (No exercise) | | | | | | | | | | |
| ◻ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | | | | | | | | |
| ◻ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) | | | | | | | | | | |
| ◻ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | | | | | | | | | | |
| **Diet** | Is your child on a special diet? | | | | | | | ◻ | Yes | ◻ | No |
| If yes, are you on a physician prescribed medical diet? | | | | | | | ◻ | Yes | ◻ | No |
| # of meals you eat in an average day? | | | | | | | | | | |
| Rank salt intake | ◻ High | | ◻ Med | ◻ Low | | | | | | |
| Rank fat intake | ◻ High | | ◻ Med | ◻ Low | | | | | | |
| **Caffeine** | ◻ None | ◻ Coffee | | ◻ Tea | ◻ Cola | | | | | | |
| # of cups/cans per day? | | | | | | | | | | |
| Sleeping | Are there any issues with sleep? | | | | | | | ◻ | Yes | ◻ | No |
| If yes, what kind? | | | | | | | | | | |
| How many hours per night does your child sleep? | | | | | | | | | | |
| Are you concerned about bedwetting? | | | | | | | ◻ | Yes | ◻ | No |
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| **Tobacco** | Does anyone use tobacco around your child? | | | | | | | ◻ | Yes | ◻ | No |
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| Development | Do you have any concerns about your child’s social development? | | | | | | |  |  |  |  |
| Do you have any concerns about your child’s physical development | | | | | | |  |  |  |  |
| Schooling | Is your child enrolled in school? | | | | | | |  |  |  |  |
| What grade is your child in? | | | | | | |  |  |  |  |
| Do you have concerns about your child’s ability to learn? | | | | | | | | | | |
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| **Personal Safety** | Does your child wear a helmet while riding a bike? | | | | | | | ◻ | Yes | ◻ | No |
| Does your child always wear a seatbelt? | | | | | | | ◻ | Yes | ◻ | No |
| Do you have concerns about vision or hearing loss for your child? | | | | | | | ◻ | Yes | ◻ | No |
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| **FAMILY HEALTH HISTORY** | | | | | | | |
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|  | AGE | | SIGNIFICANT HEALTH PROBLEMS |  | AGE | | SIGNIFICANT HEALTH PROBLEMS |
| **Father** |  | |  | **Children** | ◻ M ◻ F |  |  |
| **Mother** |  | |  | ◻ M ◻ F |  |  |
| **Sibling** | ◻ M ◻ F |  |  | ◻ M ◻ F |  |  |
| ◻ M ◻ F |  |  | ◻ M ◻ F |  |  |
| ◻ M ◻ F |  |  | **Grandmother** *Maternal* |  | |  |
| ◻ M ◻ F |  |  | **Grandfather** *Maternal* |  | |  |
| ◻ M ◻ F |  |  | **Grandmother** *Paternal* |  | |  |
| ◻ M ◻ F |  |  | **Grandfather** *Paternal* |  | |  |

| Any other concerns not mention, please list: | | | | |
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