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** |
|  |
| **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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