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MEDICAL HISTORY QUESTIONNAIRE

(For under 18 years of age)

Child's Name: _____ DOB: _____ Age: _____ Date: _____

Has your child been seen by a physician for any of the following?

Yes	No	Don't Know		Comments
___	___	_____	Asthma/RSV/Allergies	_____
___	___	_____	Bedwetting/Soiling	_____
___	___	_____	Blackouts/Fainting/Dazes Off	_____
___	___	_____	Chicken Pox	_____
___	___	_____	Dental Problems	_____
___	___	_____	Diabetes	_____
___	___	_____	Female Issues/Pregnancy/Birth Control	_____
___	___	_____	Food Allergies	_____
___	___	_____	Headaches	_____
___	___	_____	Head Injury/Unconscious	_____
___	___	_____	Hearing Problems/Tube s in Ears	_____
___	___	_____	Heart Problems	_____
___	___	_____	Measles (which)	_____
___	___	_____	Mumps	_____
___	___	_____	Repeated Infections (Strep/ear, etc)	_____
___	___	_____	Severe Muscle Strains/Broken Bones	_____
___	___	_____	Stomach Problems	_____
___	___	_____	Suicide Gesture/Attempt	_____
___	___	_____	Toileting (other than above)	_____
___	___	_____ __	Venereal Disease/STD	_____
___	___	_____	Vision Problems	_____
___	___	_____	Weight Issues	_____
___	___	_____	Other Issues Not Mentioned:	

_____

_____

Name of Primary Care Physician: _____

Address: _____

Telephone No: _____ Fax No: _____

Date of last physical exam: _____ Results: _____

_____

Shots up to date? ____ Yes ____ No

Has your child ever been seen by a psychiatrist? ____ Yes ____ No

If yes, whom: _____

Address: _____

Telephone No: _____ Fax No: _____

Medication prescribed: _____ Last Seen: _____

Has your child ever been hospitalized? ____ Yes ____ No

If yes, please explain:

Age	**How Long**	**Reason**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child ever been seen by a medical specialist? ____ Yes ____ No

If yes, please explain:

Age	**How Long**	**Reason**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication History: **Name** **Dosage** **Reason** **Effective?**

Current Medications: _____

_____

_____

Previous Medications:

_____

_____

_____

Relationship of Person Completing this Form:

____ Mother ____ Father ____ Grandmother ____ Grandfather ____ Foster Parent

____ Other: _____

Signature: _____ Legal Guardian? ____ Yes ____ No