

## Children's Health Questionnaire

Please provide information which will help construct a complete health record and plan  
Please fill out as much as is appropriate for your child's age.

Name \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_\_

### PERINATAL AND PRESCHOOL

Birthplace (hospital) \_\_\_\_\_ Birth weight \_\_\_\_\_

List any major problems during pregnancy (infection, premature labor, etc.) \_\_\_\_\_  
\_\_\_\_\_

List any major problems after birth (trouble breathing, jaundice, etc.) \_\_\_\_\_  
\_\_\_\_\_

Has your child had: A blood count (hematocrit)? \_\_\_\_\_ A vision test? \_\_\_\_\_

Has your child had any surgeries? \_\_\_\_\_ Explain: \_\_\_\_\_  
\_\_\_\_\_

### CURRENT PROBLEMS

Does your child have any chronic medical problems? (asthma, heart disease, frequent ear  
infections, etc.) \_\_\_\_\_  
\_\_\_\_\_

Does your child take any medication regularly? \_\_\_\_\_  
\_\_\_\_\_

List any allergies to medicines or to foods: \_\_\_\_\_  
\_\_\_\_\_





## SCHOOL

Please comment on your child's school progress:

Academic: \_\_\_\_\_

Social: \_\_\_\_\_

Athletic: \_\_\_\_\_

Are there any sexual development issues which you would like discussed with your child?

\_\_\_\_\_

Additional comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date