NCNM
ncnmhouse.com

1903 D Street , Bellingham, Wa 98225
P: (360)734-9500 F: (360)734-0867
www.ncnmhouse.com

# HEALTH HISTORY QUESTIONNAIRE FOR CHILDREN

**All questions contained in this questionnaire are strictly confidential and will become part of your child's medical record.**

| | | |
|---|---|---|
| **Form Completed by:** | | **Date:** |
| **Name:** *(Last, First, M.I)* | ☐ M ☐ F | **DOB** |
| **Primary Care Pediatrician:** | | **Pediatrician Phone #:** |
| **Other Healthcare Practitioners:** | | |
| **Name:** | **Type of Practice:** | **Phone Number:** |
| | | |
| | | |
| | | |
| **Please list current health concerns for your child** | | |
| Concern: | | Date of Onset: |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| **Traumas, Car accidents, Injuries?** | | |
| **Serious Illnesses:** | | |
| **Surgeries and Hospitalizations** | | |
| Date: | Reason: | Hospital: |
| | | |
| | | |
| | | |
| **Has your child ever had a blood transfusion?** | | |
| **Child's general state of health is:** ☐ Excellent ☐ Good ☐ Fair ☐ Poor | | |
| **Date of last physical:** | | **Date of last dental exam:** |

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## PRENATAL HISTORY

**Mother's age at child's birth:**

**During pregnancy, did the mother experience:**
☐ Bleeding ☐ Drug/Alcohol Abuse ☐ Hypertension ☐ Medications
☐ Physical Trauma ☐ Thyroid Problems ☐ Gestational Diabetes
☐ Other:

**During pregnancy, did the mother use any of the following:**
☐ Tobacco ☐ Alcohol ☐ Recreational Drugs ☐ Prescription Drugs
☐ Over-the-counter medications ☐ Supplements ☐ Other:
Please give details:

## BIRTH HISTORY

**Pregnancy Length:** ☐ On Time ☐ Premature _____wks ☐ Late _____wks

**Birth History:** ☐ Vaginal ☐ Cesarean Section ☐ Induced ☐ Forceps ☐ Vacuum
☐ Trauma, describe:
☐ Other:

| **Length of labor:** | **Birth weight:** | **Birth length:** |
|---|---|---|

**Any newborn problems?** ☐ Tongue Tie ☐ Difficulty nursing ☐ Juandice ☐ Rashes ☐ Seizures
☐ Hospitalization ☐ Other, describe

## IMMUNIZATION HISTORY

| | | | |
|---|---|---|---|
| ☐ Diptheria: | ☐ Pertussis: | ☐ Tetanus: | ☐ Polio: |
| ☐ Hepatitis B: | ☐ Measles: | ☐ Mumps: | ☐ Rubella: |
| ☐ H.Flu (HiB) | ☐ Tetanus booster: | ☐ Other: | |

Please Indicate any adverse reactions to vaccines:

## HEALTH & DEVLOPMENT

How was your child's health in the first year? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

If poor or fair, please describe:

At what age did your child first: Sit up Crawl Walk Talk

Describe your child's sleep pattern:

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## PAST MEDICAL HISTORY

**Does your child have, or has she/he had:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ Yes | ☐ No | Chicken pox | ☐ Yes | ☐ No | Constipation requiring doctor visit |
| ☐ Yes | ☐ No | Ear infections | ☐ Yes | ☐ No | Bladder or kidney infection |
| ☐ Yes | ☐ No | Problems with ears or hearing | ☐ Yes | ☐ No | Bed-wetting (if over 5 yo) |
| ☐ Yes | ☐ No | Seasonal Allergies | ☐ Yes | ☐ No | (girls) Started menstruation? |
| ☐ Yes | ☐ No | Problems with eyes or vision | ☐ Yes | ☐ No | (girls) Any problems with periods? |
| ☐ Yes | ☐ No | Asthma, bronchitis, croup, or pneumonia | ☐ Yes | ☐ No | Seizures or other neurologic problems |
| ☐ Yes | ☐ No | Heart problems or murmur | ☐ Yes | ☐ No | Frequent headaches |
| ☐ Yes | ☐ No | Anemia or bleeding problem | ☐ Yes | ☐ No | Chronic or recurrent skin problems |
| ☐ Yes | ☐ No | Frequent abdominal pain | ☐ Yes | ☐ No | Diabetes or thyroid problems |

Has your child had antibiotics? If so, how many times and for what reasons?

## FAMILY HEALTH HISTORY

**Is your child adopted?** ☐ Yes ☐ No

**Has any family member been diagnosed with:**

| | Yes | No | Who? Age? | | Yes | No | Who? Age? |
|---|---|---|---|---|---|---|---|
| Asthma | ☐ | ☐ | | Diabetes | ☐ | ☐ | |
| Emphysema | ☐ | ☐ | | Colitis/Crohn's/Celiac | ☐ | ☐ | |
| Severe Allergies | ☐ | ☐ | | Addiction Problems | ☐ | ☐ | |
| Thyroid Problems | ☐ | ☐ | | Cancer | ☐ | ☐ | |
| Stroke/Blood clots | ☐ | ☐ | | Mental Illness | ☐ | ☐ | |
| Heart Disease | ☐ | ☐ | | Depression | ☐ | ☐ | |
| Heart Attack | ☐ | ☐ | | Anxiety | ☐ | ☐ | |
| High Blood Pressure | ☐ | ☐ | | Deafness | ☐ | ☐ | |
| High Cholesterol | ☐ | ☐ | | Developmental Delay | ☐ | ☐ | |
| Kidney Disease | ☐ | ☐ | | Bedwetting After 10y | ☐ | ☐ | |
| Gallbladder Disease | ☐ | ☐ | | MTHFR Mutation | ☐ | ☐ | |
| Osteoporosis | ☐ | ☐ | | Other: | ☐ | ☐ | |
| Liver Disease | ☐ | ☐ | | Other: | ☐ | ☐ | |
| Anemia | ☐ | ☐ | | Additional Information: | | | |
| Blood Disorder | ☐ | ☐ | | | | | |

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## MEDICATIONS

INCLUDE CURRENT PRESCRIPTION MEDICATIONS, OVER THE COUNDER DRUGS, VITAMINS, HERBS, HOMEOPATHICS, ETC...

| Start Date | Name & Brand | Dose/Strength | Frequency |
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## ALLERGIES

| Name of drug, environmental or food allergy | Reaction |
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