

The Children's Clinic of Klamath Pediatric Updated History Questionnaire

Today's Date: _____

Child's Name: _____ Nickname: _____ Birthdate: _____

FAMILY HISTORY:

Has your child or a family member had any of the following? If yes, check appropriate box:

Patient	Family Member	Comments
<input type="checkbox"/> Allergies	<input type="checkbox"/>	
<input type="checkbox"/> Anemia	<input type="checkbox"/>	
<input type="checkbox"/> Asthma	<input type="checkbox"/>	
<input type="checkbox"/> Birth defect	<input type="checkbox"/>	
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/>	
<input type="checkbox"/> Breast problems	<input type="checkbox"/>	
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	
<input type="checkbox"/> Drug/alcohol abuse	<input type="checkbox"/>	
<input type="checkbox"/> Ear infection (How many?)	<input type="checkbox"/>	
<input type="checkbox"/> Feeding problems	<input type="checkbox"/>	
<input type="checkbox"/> Headaches (migraines)	<input type="checkbox"/>	
<input type="checkbox"/> Heart problems	<input type="checkbox"/>	
<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	
<input type="checkbox"/> High blood pressure	<input type="checkbox"/>	
<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/>	
<input type="checkbox"/> Mental illness / depression	<input type="checkbox"/>	
<input type="checkbox"/> Seizures (convulsions)	<input type="checkbox"/>	
<input type="checkbox"/> Skin conditions (e.g., eczema)	<input type="checkbox"/>	
<input type="checkbox"/> Weight problems	<input type="checkbox"/>	
<input type="checkbox"/> Other	<input type="checkbox"/>	

Hospitalizations (date and reason):
1. _____ _____
2. _____ _____

Daily Medications (include over-the-counter):		
1. Fluoride	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Herbs	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Vitamins	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4.		
5.		
6.		
Glasses	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hearing Aid	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Where has your child received previous care?: _____

Has your child seen a dentist in the past year? Yes No

Has your child seen an eye doctor in the past year? Yes No

Has your child had alternative medical care? Yes No

If yes, which alternative medical provider(s) has your child seen? _____

With whom does this child live most of the time? Both Parents Mother Father Other Relatives Foster Parent

Does anyone in the home smoke? Yes No

Is there a smoke alarm in the home? Yes No

Are there firearms in the home? Yes No

The Children's Clinic of Klamath
Updated Medical History
Questionnaire

For children up to 12 months old:

During your pregnancy with this child, did you:

- Have high blood pressure? Yes No
- Have diabetes or sugar in your urine? Yes No
- Take any medications? Yes No
- alcohol Yes No
- drugs Yes No
- Smoke cigarettes? Yes No

- Deliver by C-section? Yes No
- Have any problems with labor or delivery? Yes No
- How many days did baby stay in hospital? _____

Comments: _____

For children 3 years and older:

CHILD'S SCHOOL HISTORY:

Where does your child go to school? _____ What grade? _____

Has your child ever repeated or been held back a grade? Yes No

Attended a special class? Yes No

Any behavior problems in school? Yes No

Any academic problems? Yes No

If answer is "yes" to any of the above questions, please describe.

