Partnership Community Health Center

Child Health History Questionnaire (17 years old and younger)

Please fill out completely and honestly. Your responses will be kept confidential.
*Mark "YES" if you have **history of or currently have** the health issue. "?" =Don't Know*

Cardiovascular/Heart					*Follow-Up Comments*	
Congenital Heart Defect	Yes	/ No	/	?	Has it been repaired?	When?
Heart Surgery	Yes	/ No	/	?		
High Blood Pressure/Hypertension	Yes	/ No	/	?		
Hematologic/Blood Disorders						
Anemia	Yes	/ No	/	?		
Abnormal Bleeding	Yes	/ No	/	?		
Respiratory						
Asthma	Yes	/ No	/	?	Do you carry an inhaler with you?	
Endocrine/Metabolic						
Diabetes	Yes	/ No	/	?	Type 1 or Type 2?	
Thyroid Problem	Yes	/ No	/	?		
Gastrointestinal						
Acid Reflux/GERD/Frequent Heartburn	Yes	/ No	/	?		
Frequent Vomiting	Yes	/ No	/	?		
Hepatic/Liver						
Hepatitis	Yes	/ No	/	?	What type?	
Liver Disease	Yes	/ No	/	?		
Neurological						
Epilepsy/Seizures	Yes	/ No	/	?	When was the last one?	
Injury to the head	Yes	/ No	/	?		
Any sensory disorders (seeing/hearing)	Yes	/ No	/	?		
Mental/Behavioral Health						
Learning Disabilities	Yes	/ No	/	?		
Communication Difficulties	Yes	/ No	/	?		
Autism Spectrum Disorder	Yes	/ No	/	?		
Eating Disorder	Yes	/ No	/	?		
Other mental health problems	Yes	/ No	/	?		
Other						
Current on all vaccinations	Yes	/ No	/	?		
Recent or Current Infection (Ear, Throat, Eye, Respiratory, etc.)	Yes	/ No	/	?		
Cancer	Yes	/ No	/	?	When?	Type?

Pregnant	Yes / No / ?	Estimated Due Date:
Tobacco/Alcohol/Substance Abuse	Yes / No / ?	
Anything else we should know about the patient's medical history?	Yes / No / ?	
Comments:		
Does the patient regularly see a physician?	Yes / No / ?	
Recent surgeries/hospitalizations?	Yes / No / ?	

Dental History	
Is there a current toothache or other immediate dental problem?	Yes / No / ?
Has the child ever had a toothache?	Yes / No / ?
Has the child had any injury to the mouth, teeth, or jaws?	Yes / No / ?
Is this the child's first dentist visit?	Yes / No / ?
Does the child have a habit of sucking thumb/fingers/pacifiers?	Yes / No / ?
Does the child grind his/her teeth?	Yes / No / ?
How often is tooth brushing performed?	
How often does the child floss?	
Does someone assist the child with brushing and cleaning the teeth?	Yes / No / ?
Does someone inspect for thoroughness after brushing/flossing?	Yes / No / ?
Does the child use fluoridated toothpaste?	Yes / No / ?
Is the primary water supply from a well or the city?	
Does the child regularly consume beverages such as soda, juice, energy drinks, or sports drinks?	Yes / No / ?
Does the child regularly consume sugar-free beverages such as diet soda, Crystal Lite, or flavored water?	Yes / No / ?
Has the child been to the ER for dental pain?	Yes / No / ?
Does the child have regular dental exams?	Yes / No / ?
When was the last dental exam?	

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Allergy	Reaction

Medication	Dose, frequency