MERCED FACULTY ASSOCIATES PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please approximate. Add any notes you think are important. **ALL ANSWERS CONTAINED IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.**

Main reason for today's visit: _____ other concerns: _____

CURRENT MEDICATIONS – Please list the medications you currently take. If you are not currently taking any medications, please check the "none" box to the right. ☐ **None**
1.
2.
3.
4.
MEDICATION ALLERGIES **List all medications allergic to:** ☐ **None**
1.
2.
3.
4.
PHARMACIES – list the pharmacies used, both local and mail away.
1. Street, Town:
2. Street, Town:

BIRTH HISTORY- Please answer/check mark what pertains to your child.	
☐ Birth Weight:	☐ Check if the mother smoked during pregnancy.
☐ Check if adopted.	☐ Check if the mother drank alcohol during pregnancy.

PAST MEDICAL HISTORY - Please check the box if you have had or experienced these symptoms or medical issues. If none, indicate by checking the "none" box to the right. ☐**None**		
☐ Abdominal Pain	☐ Blood in Stool	☐ Lung Disease/Pneumonia
☐ Anemia	☐ Chicken Pox	☐ Mental Illness
☐ Allergies, Seasonal	☐ Constipation	☐ Seizures/Epilepsy
☐ Anxiety Disorder	☐ Developmental or Behavior Disorders	☐ Skin Problems
☐ Asthma	☐ Ear or Hearing Problems	☐ Traumatic Illness or Injuries
☐ Birth Defects or Inherited Disease	☐ Heart Murmur	☐ Vision or Eye Problems
☐ Bladder or Kidney Problems		

FAMILY HISTORY	☐ **None**
☐ Alcohol/Substance Abuse	☐ Developmental Disorders
☐ Allergies, Seasonal	☐ Diabetes
☐ Anxiety Disorder	☐ Epilepsy/Seizures
☐ Asthma	☐ Headaches/Migraines
☐ Bleeding Disorder	☐ High Cholesterol
☐ Cancer	☐ Immune Problems
☐ Depression	

SOCIAL HISTORY/LIFESTYLE	**(Circle)**
Mother/Stepmother/Guardian Name:	
Father/Stepfather/Guardian Name:	
Siblings Name(s):	
Diet:	Regular, Vegetarian, Gluten free, lactose free
Passive Smoke Exposure?	Y N
Smoke/CO detectors in home?	Y N
Seat belt/car seat used routinely?	Y N
Sunscreen routinely?	Y N
MATURE PEDIATRICS ONLY	
Alcohol intake:	None, Occasional, Moderate, Heavy
Smoking status:	Never, Former, Current
Chewing tobacco:	Never, Former, Current
Illicit drugs:	Y N
Sexually active:	Y N

SURGICAL PROCEDURES/HOSPITALIZATIONS	
MONTH/YEAR	ILLNESS/OPERATION

To my understanding, this represents an accurate portrayal of my health history.

_____

Signature Date