PRIMARY CARE SPECIALISTS, INC.

MEDICAL QUESTIONNAIRE - CHILDREN

Patient's Name ____
Date of birth ________________Age__________Acc#___________________
Date of Visit_________________

PAST HISTORY:

1. Does your child now have or did he/she ever have any of these conditions? Check the appropriate box.

[ ] measles	[ ] asthma	[ ] diabetes
[ ] mumps	[ ] pneumonia	[ ] heart trouble
[ ] chicken pox	[ ] tuberculosis	[ ] high blood pressure
[ ] diphtheria	[ ] HIV / AIDS	[ ] kidney trouble
[ ] polio	[ ] liver trouble / hepatitis	[ ] seizures
[ ] sickle cell	[ ] mental illness	[ ] anemia
[ ] cancer	[ ] other_________________	

2. List any serious injuries:

____
____

3. List any hospitalizations or surgeries. Include the approximate dates:

____
____
____
____
____

FAMILY HISTORY:

1. Is child's mother living?____ If not, what did she die from? __________________
2. Is child's father living? ____ If not, what did he die from? ___________________
3. How many brothers does child have? Living ______, Deceased ________
4. How many sisters does child have? Living _______, Deceased ________
5. Does any one in child's family (mother, father, brothers, sisters, aunts, uncles, grandparents, etc.) have any of these conditions? Check the appropriate box.

Family member(s)

[ ] tuberculosis ____
[ ] heart disease ____
[ ] diabetes ____
[ ] strokes ____
[ ] kidney disease____
[ ] sickle cell ____
[ ] cancer (type if known)____
[ ] arthritis ____
[ ] liver disease____
[ ] stomach/bowel disease____

[ ] migraine headaches____
[ ] anemia ____
[ ] high blood pressure(hypertension)________________________________
[ ] seizures ____
[ ] HIV/AIDS ____
[ ] Other ____

ALLERGIES:
Are you allergic to any medication(s)? ____ If so, what are they? ____________
____

IMMUNIZATIONS:
Provide immunization / shot record for nurses to copy if available.
Has your child had the following immunizations? Check the appropriate box.
[ ] small pox [ ] measles [ ] rubella [ ] pertussis [ ] tetanus
[ ] typhoid [ ] mumps [ ] diphtheria [ ] polio [ ] hepatitis
[ ] unsure or unknown

MEDICATIONS:
List all medications and their doses (if known) ?___________________________
____
____
____
____
If you brought your child's medications with you, show them to the nurse at the time of the interview.

HABITS:
1. How many meals a day does your child eat?_____________________________
2. How many hours of sleep per night does your child get?____________________
3. How often does your child have a bowel movement?_______________________

SOCIAL HISTORY:
1. What grade is your child in school? _______________________________________
2. What type of home does your child live in? Check the appropriate box.
   [ ] house [ ] apartment [ ] condo [ ] Other_____________________________
3. Who lives in the home with your child? ____________________________________

REVIEW OF SYSTEMS:
If you have any of the following problems, please check the appropriate box.

HEENT
[ ] Decreased hearing
[ ] Failing or blurred vision
[ ] Nose bleeds - recurrent
[ ] Sinus trouble
[ ] Sore throat - frequent
[ ] Hayfever / allergies
[ ] Eye infections - frequent
[ ] Ear infections - frequent

CARDIOPULMONARY
[ ] Chronic cough / bronchitis
[ ] Asthma / wheezing
[ ] Shortness of breath
[ ] Chest pain
[ ] Heart murmur
[ ] Palpitations / Irregular heart beat

GASTROINTESTINAL
[ ] Loss of appetite
[ ] Difficulty swallowing
[ ] Indigestion or heartburn
[ ] Persistent nausea / vomiting
[ ] Peptic ulcers
[ ] Stomach pain
[ ] Constipation
[ ] Diarrhea
[ ] Bloody or black stools

GENERAL
[ ] Dizzy spells
[ ] Fainting spells
[ ] Weight loss
[ ] Bruise easy
[ ] Bed wetting

URINARY
[ ] Frequent urination
[ ] Frequent urine infections
[ ] Painful urination
[ ] Blood in urine
[ ] Penis discharge
[ ] Vaginal discharge

NEUROLOGICAL
[ ] Seizures / convulsions
[ ] Muscle weakness
[ ] Headaches - frequent

MUSCULOSKELETAL
[ ] Back pain
[ ] Foot pain
[ ] Leg pain when walking

PSYCHIATRIC
[ ] Nervousness
[ ] Depression
[ ] Mental Illness
[ ] Sleeping difficulty
[ ] Mental illness
[ ] Attention deficit disorder

SKIN
[ ] Rashes
[ ] Psoriasis / eczema
[ ] Hives / Itching