

**ST. JOHN'S MERCY MEDICAL CENTER
DEPARTMENT OF FAMILY MEDICINE**

**CHILD HEALTH QUESTIONNAIRE
(UNDER 18 YEARS OF AGE)**

CHILD'S NAME: _____ AGE: _____

FAMILY HISTORY

1. Who lives at home? _____
2. How many brothers _____, ages _____; sisters _____, ages _____ does this child have?
3. Do any of the family members (parents, grandparents, brothers, sisters) have:

(Check all that apply)

| | |
|------------------------|-----------------------------|
| Diabetes _____ | Heart Disease _____ |
| Hay Fever _____ | Kidney Disease _____ |
| Convulsions _____ | Depression _____ |
| Asthma _____ | Alcohol/Drug Problems _____ |
| Migraines _____ | Bleeding Tendencies _____ |
| Other (specify): _____ | |

PREGNANCY

YES NO EXPLAIN

| | | | |
|--|-----|-----|-------|
| Was pregnancy normal full-term, nine months? | ___ | ___ | _____ |
| Mother – any illnesses during pregnancy? | ___ | ___ | _____ |
| Child – any trouble the first year of life? | ___ | ___ | _____ |
| Birth Weight: _____ | | | |

DEVELOPMENT

How is your child's: Growth _____

Development _____

School Performance _____

GENERAL HISTORY

| | | | | |
|---------------------|---------|---------|---------|---------|
| Hospitalizations | 1 _____ | 2 _____ | 3 _____ | 4 _____ |
| Surgeries | 1 _____ | 2 _____ | 3 _____ | 4 _____ |
| Current Medications | 1 _____ | 2 _____ | 3 _____ | 4 _____ |

Is your child bothered by:
(Check all that apply)

Skin rashes _____

Teeth problems – cavities _____

Sinus problems _____

Frequent ear problems _____

History heart murmur _____

Chest pain _____

Feeding problems _____

Gas/bowel problems _____

Urinary problems _____

Bone/joint pains _____

Headaches _____

Convulsions _____

Anxiety/depression _____

Are immunizations up-to-date? _____

What is your opinion of your child's general health? _____

Do you think your child is happy? _____