

FREMONT COMMUNITY HEALTH SERVICES CHILD HEALTH QUESTIONNAIRE

DATE: _____ CHILD'S NAME _____

BIRTHDATE: _____ SEX: _____ BIRTH WEIGHT: _____
 MONTH DAY YEAR M F

FAMILY MEMBERS: PLEASE MARK THOSE WHO HAVE DIED WITH A *, AND THOSE WHO LIVE IN ANOTHER HOUSEHOLD WITH A #.

MOTHER: AGE: _____ NAME: _____ FATHER: AGE: _____ NAME: _____

BROTHERS: _____ SISTERS: _____

OTHERS: _____

PLEASE LIST ANY LONG-TERM MEDICATIONS WHICH THE CHILD HAS USED, INCLUDING NON-PRESCRIPTION DRUGS:

PLEASE LIST ANY ALLERGIES, ESPECIALLY TO DRUGS:

DURING PREGNANCY, WAS THE BABY EXPOSED TO:

____ ILLNESS OF MOTHER ____ MEDICATION ____ HORMONES
 ____ X-RAYS ____ SMOKING BY MOTHER ____ ALCOHOL, OTHER DRUGS

WERE THERE PROBLEMS WITH OR SHORTLY AFTER BIRTH?

____ EARLY OR LATE BIRTH ____ BREATHING PROBLEMS ____ HARD LABOR
 ____ C-SECTION ____ DELAY IN GOING HOME ____ OTHER

PLEASE CHECK ANY OF THE FOLLOWING WHICH THE CHILD HAS HAD:

____ ANEMIA ____ ECZEMA ____ PNEUMONIA
 ____ ASTHMA ____ HAYFEVER ____ SEIZURES
 ____ BEHAVIOR PROBLEMS ____ HEARING LOSS ____ SPEECH PROBLEMS
 ____ CONSTIPATION ____ HOSPITALIZATION ____ SURGERY
 ____ EAR INFECTIONS ____ MAJOR INJURY ____ WETTING PROBLEMS
 ____ EATING PROBLEMS ____ PARASITES ____ OTHER MAJOR ILLNESS

IF YOU HAVE A COPY OF THE CHILD'S IMMUNIZATION RECORD, SKIP THIS PART AND PRESENT THE RECORD FOR COPYING, OTHERWISE, GIVE APPROXIMATE DATES:

DIPHTHERIA/PERTUSSIS/TETANUS (DPT): #1 _____ #2 _____ #3 _____ #4 _____ #5 _____

DIPHTHERIA/TETANUS (DT) BOOSTER: _____ HIB or PROHIBIT _____

MEASLES: _____ POLIO (OPV): #1 _____ #2 _____ #3 _____ #4 _____ #5 _____

MUMPS: _____ OTHER _____

RUBELLA: _____ TB: _____

FAMILY MEDICAL HISTORY: PLEASE LIST ANY FAMILY MEMBERS (GP-GRANDPARENTS, F-FATHER, M-MOTHER, B-BROTHER, S-SISTER, C-CHILD, O-OTHERS) WHO HAVE:

____ ANEMIA ____ DIABETES ____ NERVOUS DISORDER
 ____ ARTHRITIS ____ EPILEPSY, SEIZURES ____ STROKE
 ____ ASTHMA, ALLERGIES ____ GLAUCOMA ____ TUBERCULOSIS
 ____ CANCER ____ HEART DISEASE ____ ULCERS
 ____ CHEMICAL DEPENDENCY ____ HIGH BLOOD PRESSURE ____ OTHER MAJOR ILLNESS