Allegro PEDIATRICS

New Patient Health History Questionnaire

Name of Child _____ **Birth Date** _____

Past Medical History Has your **child** had the following? **Check box** and **Explain with year of diagnosis** for all items that apply.

- ☐ 1) Major concerns from family for child's health _____
- ☐ 2) Abdominal pain frequently _____
- ☐ 3) Anemia _____
- ☐ 4) Asthma _____
- ☐ 5) Bladder or kidney infection _____
- ☐ 6) Bleeding Problem _____
- ☐ 7) Bronchiolitis _____
- ☐ 8) Bronchitis _____
- ☐ 9) Constipation _____
- ☐ 10) Diabetes _____
- ☐ 11) Ear infections _____
- ☐ 12) Emotional Problem _____
- ☐ 13) Eye problem _____
- ☐ 14) Headaches frequently _____
- ☐ 15) Hearing loss _____
- ☐ 16) Heart murmur _____
- ☐ 17) Heart problem _____
- ☐ 18) Hospitalization _____
- ☐ 19) Injuries or accidents _____
- ☐ 20) Pneumonia _____
- ☐ 21) Pregnancy or newborn period problems _____
- ☐ 22) Seizures _____
- ☐ 23) Serious illness or medical condition _____
- ☐ 24) Skin problem _____
- ☐ 25) Thyroid or other endocrine problems _____
- ☐ 26) Vision problem _____
- ☐ 27) Other healthcare specialists providing care _____
- ☐ 28) Other significant problems _____

Past Medical History (extra space) for Item # with explanations _____

_____

- ☐ **Surgery** _____
- ☐ **Medications** prescribed or taken on a regular basis– _____
- ☐ **Allergies to medicine or drugs** _____
- ☐ **Allergies** to food or environmental triggers _____

Family History: Check if any **family members** had the following. Please **include relationship to child** and **age at onset**.

- ☐ Alcohol or Drug abuse _____
- ☐ Allergies _____
- ☐ Anemia _____
- ☐ Asthma _____
- ☐ Bleeding Disorder _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Early/Sudden death _____
- ☐ Epilepsy/convulsions _____
- ☐ Gastrointestinal problems _____
- ☐ Hearing loss/Deafness _____
- ☐ Heart disease _____
- ☐ High blood pressure _____
- ☐ High cholesterol _____
- ☐ Immune problems _____
- ☐ Kidney disease _____
- ☐ Liver Disease _____
- ☐ Mental Illness / Depression _____
- ☐ Skin Problems _____
- ☐ Other significant history _____

Social History – Who does your child live with? _____ Primary Language(s) Spoken at Home _____

☐ Smokers in the household _____ ☐ Significant issues in family or household _____

Parents' Names & Birthdates _____

Employment Info _____

Siblings' Names & Birthdates _____

With my signature, I state that, to the best of my knowledge, the above answers are correct.

Signature _____ Date _____

Provider Initials & Date _____

EHR Data Entry & Date _____

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