UNIVERSITY OF WYOMING

Albany Community Health Clinic
1174 North 22nd Street
Laramie, WY 82072
(307) 766-3313
Fax: (307) 766-3316
Email: achc@uwyo.edu

PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. All questions contained in the questionnaire are optional and will be kept strictly confidential.

NAME:___________________________________ DOB:________________________________

Main Reason for today's visit:____

____

ALLERGIES

ALLERGY REACTION

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

FAVORITE PHARMACY: ____

WHO IS YOUR PRIMARY CARE PROVIDER: ____

MEDICATIONS

DRUG NAME	STRENGTH	FREQUENCY TAKEN

IMMUNIZATION HISTORY:

Circle all that apply and report most recent date.

Chickenpox	Date: _____________	MMR (Measles, Mumps, Rubella)	Date: _______________
Flu Shot	Date: _____________		
Gardasil/HPV	Date: _____________	Pneumonia	Date: _______________
Hepatitis A	Date: _____________	Tdap (Tetanus and Pertussis)	Date: _______________
Hepatitis B	Date: _____________		
Meningococcus	Date: _____________	Zostavax (Shingles)	Date: _______________

PAST MEDICAL HISTORY

Please list any known health conditions and important past health problems (i.e. asthma, hernia, reflux):

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PAST SURGICAL HISTORY

SURGERY	REASON	YEAR

FAMILY HEALTH HISTORY

Mark all that apply

Relation	Alcoholism	Arthritis	Depression	Cancer	Diabetes	Genetic Disease	Heart Disease	Hypertension	Osteoporosis	Stroke
Father										
Mother										
Brother/ Sister										
Brother/ Sister										
Grandfather (Paternal)										
Grandmother (Paternal)										
Grandfather (Maternal)										
Grandmother (Maternal)										

Other: ____

Other: ____

SOCIAL HISTORY

Is any special diet followed? Y or N If yes, please specify: ______________________________

Caffeine Intake: None Occasional Moderate Heavy # of cups/cans per day? __________________

Have you ever used tobacco? Y or N If yes, how much? Cigarettes: ______________________

Chew: ______________________

Other: ______________________

Is there exposure to second hand smoke? Y or N

Exercise level? None Occasional Moderate Heavy

Please list any sporting activities: ____

Parents' marital status: Married Unmarried Separated Divorced Widowed

Home situation: Both parents Father Mother Relative Other: ____

Siblings: ____

Child care: None Relative Private/sitter Daycare/Preschool

Are there pets in home? Y N If so, what? ____

Smoke alarm in home? Y or N

Do you wear your seat belt routinely? Y or N

Is insect repellent used routinely? Y or N

Is sunscreen routinely used? Y or N

Are guns present at home? Y or N

Grade in school? ____________________ School Name: ____

Fluoride status of home water? Fluoridated Non-fluoridated Unknown

Pool exposure? Y or N

Bike helmet used? Y or N

Problems with bullying? Y or N

Any other important information? ____

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