PEDIATRIC ASSOCIATES OF GREATER SALEM
Health History Questionnaire to Young Adulthood

Identification Information: Today's Date _____

Patient's Name _____ Male____ Female____ Date of Birth _____ Age ____Yrs. ____Mos.

Parent or Guardian's Name _____

Address: _____ Telephone: _____

A. REASON FOR VISIT

1. Comprehensive periodic examination ____Yes ____No
2. Medical problem(s): Please list. About when did they begin? What concerns you most? _____

_____

_____

_____

3. If patient is, or has been, treated for any other illnesses or medical problems by other physicians, please describe the problems and write the name of the physician or medical facility treating him/her.

Illness or Medical Problem	Physician or Medical Facility	Telephone Number

CURRENT OR PAST HEALTH HISTORY

Please ✔ the appropriate answer unless otherwise specified. If in doubt about the question, please circle it. Your doctor or nurse will review your answers with you.

_____ Parent Completing: Does your child have or ever had any of the following?

_____ Patient Completing: Do you have or ever had any or the following?

EYES

1. Crossed or wandering eyes? ____No ____Yes
2. Vision changes past year? ____No ____Yes
3. Wear glasses or contact lenses? ____No ____Yes
4. Eye muscle surgery? ____No ____Yes
5. Trouble reading or watching TV? ____No ____Yes

EARS

6. Repeated infections? ____No ____Yes
7. Chronic drainage? ____No ____Yes
8. Ear tubes? ____No ____Yes
9. Speech problems or speech delay? ____No ____Yes
10. Deafness or decreased hearing? ____No ____Yes

NOSE AND THROAT

11. Trouble breathing through the nose? ____No ____Yes
12. Frequent colds? ____No ____Yes
13. Nose allergy symptoms? Itchy nose? ____No ____Yes
14. Nose bleeds? ____No ____Yes
15. Frequent sore or strep throat infections? ____No ____Yes
16. Still have your tonsils? ____No ____Yes

TEETH

17. Decay or defects? ____No ____Yes
18. Bite (occlusion) defects? ____No ____Yes
19. Date of last visit to Dentist? _____

    to Orthodontist? _____

SKIN

20. Birthmarks or moles? ____No ____Yes
21. Acne? ____No ____Yes
22. Heavy tan or often sunburned? ____No ____Yes

CHEST

23. Chronic cough? ____No ____Yes
24. Short of breath with activity? ____No ____Yes
25. Wheezing with exercise? ____No ____Yes
26. Asthma/hay fever? ____No ____Yes
27. Pneumonia? ____No ____Yes
28. Tuberculosis skin test change? ____No ____Yes

HEART

29. Heart murmur? ____No ____Yes
30. Heart beats too fast? ____No ____Yes
31. Palpitations or irregular heart beat? ____No ____Yes
32. Pain over the heart? ____No ____Yes
33. Chest or shoulder pain with activity? ____No ____Yes
34. High blood pressure? ____No ____Yes
35. Blood cholesterol test done? ____No ____Yes

BLOOD

36. Anemia? ..... ___No ___Yes
37. Bleeding or easy bruising problems? ___No ___Yes
38. Clotting problems? (Hemophilia?). ___No ___Yes

DIGESTIVE TRACT

39. Chronic or frequent diarrhea? ..... ___No ___Yes
40. Constipation? ..... ___No ___Yes
41. Recurrent vomiting? ..... ___No ___Yes
42. Recurrent abdominal pain? ..... ___No ___Yes
43. Bloody bowel movements? ..... ___No ___Yes
44. Jaundice or yellow skin? ..... ___No ___Yes
45. Prolonged loss of appetite? ..... ___No ___Yes
46. Overeating followed by vomiting? .. ___No ___Yes

URINARY TRACT

47. Bed wetting problems? ..... ___No ___Yes
48. Infection one or more times? ..... ___No ___Yes
49. Bloody or dark colored urine? ..... ___No ___Yes
50. Difficulty starting or stopping the stream? ..... ___No ___Yes
51. Painful or frequent urination? ..... ___No ___Yes

MUSCULO-SKELETAL

52. Limb or growing pains? ..... ___No ___Yes
53. Painful or swollen joints? ..... ___No ___Yes
54. Problems with muscle coordination or strength? ..... ___No ___Yes
55. Posture problems? ..... ___No ___Yes
56. Foot or ankle problems? ..... ___No ___Yes
57. Severe back pain? ..... ___No ___Yes
58. Scoliosis/abnormal curve of back? ..... ___No ___Yes
59. Lump or swelling of any bone? ..... ___No ___Yes

NEUROLOGICAL

60. Headaches? ..... ___No ___Yes
61. Any fatigue or listlessness? ..... ___No ___Yes
62. Any dizziness? ..... ___No ___Yes
63. Any loss of balance? ..... ___No ___Yes
64. Convulsion, seizure, or fit? ..... ___No ___Yes
65. Difficulty controlling use of hands, arms, or legs? ..... ___No ___Yes

GENERAL

66. Recent weight loss? Or gain? ..... ___No ___Yes
67. Too short? Too tall? ..... ___No ___Yes
68. Too fat? Too thin? ..... ___No ___Yes
69. Easy tiring or fatigability? ..... ___No ___Yes
70. Heavy or excessive appetite? ..... ___No ___Yes
71. Trouble sleeping? ..... ___No ___Yes

CHILDHOOD DISEASES

72. Whooping cough? ..... ___No ___Yes
73. Chicken Pox? ..... ___No ___Yes
74. Measles? ..... ___No ___Yes
75. Rubella (3-day measles)? ..... ___No ___Yes
76. Mumps? ..... ___No ___Yes
77. Polio? ..... ___No ___Yes
78. Kawasaki Disease? ..... ___No ___Yes

PUBERTY

BOYS ONLY: Approx. age of onset

79. Voice change? ..... ___Yrs. ___Mos.
80. Muscular growth? ..... ___Yrs. ___Mos.
81. Axillary hair present? ..... ___Yrs. ___Mos.
82. Pubic hair present? ..... ___Yrs. ___Mos.
83. Testes growing? ..... ___Yrs. ___Mos.
84. Penis growing? ..... ___Yrs. ___Mos.
85. Swollen painful breast(s)? ..... ___Yrs. ___Mos.
86. Interest in girls? ..... ___Yrs. ___Mos.

GIRLS ONLY: Approx. age of onset

87. Breasts developing? ..... ___Yrs. ___Mos.
88. Menstrual periods present? ..... ___Yrs. ___Mos.
89. Age & date of first menstrual period _____
90. Regular periods? ..... ___No ___Yes
91. Pain or discomfort with period? ..... ___No ___Yes
92. Heavy flow? ..... ___No ___Yes
    Scant flow? ..... ___No ___Yes
93. Use? ..... ___Tampons ___Pads ___Both

94. ARE YOU PHYSICALLY HANDICAPPED OR LIMITED IN ANY WAY? ..... ___No ___Yes

If Yes, please name or describe: _____

_____

95. DO YOU HAVE ANY QUESTIONS OR CONCERNS TO DISCUSS WITH YOUR DOCTOR? ..... ___No ___Yes

SUMMARY OF QUESTIONNAIRE

(By Nurse or Doctor)

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