north seattle PEDIATRICS

Health History Questionnaire

This questionnaire must be completed before your Physical Exam (age > 6years) or before your physician can sign any activity/camp/sports forms.

Name of child _____

Birthdate _____

Circle Yes or No to the following questions. **Explain** all 'Yes' responses in the space provided (to the right).

1. Injury or illness since last checkup? ----------Yes/No_____
2. Strain, sprain, fracture, joint pain or swelling?----------Yes/No_____
3. Chronic illnesses, hospitalization or surgeries?----------Yes/No_____
4. Allergies to medications, insects or food?----------Yes/No_____
5. Any medications or supplements of any type?----------Yes/No_____
6. Ever restricted from sports/activity by a physician?---------Yes/No_____
7. Dizziness, passed out, chest pain with exercise/activity?-Yes/No_____
8. Concussion, "knocked out", unconsciousness, memory loss, seizure?---------- Yes/No_____
9. Problems while exercising in the heat?----------Yes/No_____
10. Stinger, burner, pinched nerve: numbness or tingling in arms, hands, legs, or feet?----------Yes/No_____
11. Severe/frequent headache? Neck pain?----------Yes/No_____
12. Any skin problems?----------Yes/No_____
13. History of sudden death in a close relative <50 yrs old?---Yes/No_____
14. History of high blood pressure or heart murmur?----------Yes/No_____
15. Asthma, allergies, wheezing, difficulty breathing?----------Yes/No_____
16. Glasses, contacts, vision or eye problems?----------Yes/No_____
17. Any concerns regarding periods?----------Yes/No/NA_____

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

Signature of Parent or Legal Guardian, or Patient 18 years of age or older:

Signature_____

Date_____

Office use only
Provider's initials_____
Date reviewed_____