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Health History Questionnaire

Payer / Responsible Party Information			
Patient Name	Patient Date of Birth	Patient Address	
Person Responsible for Bill	Address (if different from patient)	Home Phone	Cell Phone
Employer	Employer Address	Employer Phone	

Primary Insurance	Group#	Policy#	Subscriber's SS#
Subscriber / Insured Name	Date of Birth	Patient's Relationship to Subscriber	
Secondary Insurance	Group#	Policy#	Subscriber's SS#
Subscriber / Insured Name	Date of Birth	Patient's Relationship to Subscriber	

Family Health History

Family Member	**Name**	**Age**	**Health Problem(s)**
Father			
Mother			
Brother			
Sister			

Patient Birth History

Any family child deaths:

Patient's Birth Weight: # Weeks at Delivery Delivery Type: ☐Vaginal ☐C-Section

Comments regarding pregnancy / labor / delivery

Patient Health History

Has the patient ever had: (Please check the appropriate answer)

Chicken Pox	☐Yes	☐No	Diabetes	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Eczema / Skin Problems	☐Yes	☐No	Pneumonia	☐Yes	☐No	Convulsion / Epilepsy	☐Yes	☐No
High Blood Pressure	☐Yes	☐No	Croup	☐Yes	☐No	Emotional Disorder	☐Yes	☐No
Asthma	☐Yes	☐No	TB / Lung Disease	☐Yes	☐No	Cancer	☐Yes	☐No
Frequent Sore Throats	☐Yes	☐No	High Cholesterol	☐Yes	☐No	Allergies	☐Yes	☐No
Frequent Colds	☐Yes	☐No	HIV / AIDS	☐Yes	☐No	Hepatitis	☐Yes	☐No
Frequent Ear Infections	☐Yes	☐No	Handicaps / Disabilities	☐Yes	☐No	Congenital Heart Defect	☐Yes	☐No
Kidney / Bladder Problems	☐Yes	☐No	Please explain any medical problem(s) your child may have:					
Measels / Mumps	☐Yes	☐No						
Hemophilia	☐Yes	☐No						
Heart Murmur	☐Yes	☐No						