YOUTH HEALTH HISTORY QUESTIONNAIRE

	Birth Date:		Today's date: Height:					
This qu	-	n providing a general overvi led as possible when answe	ew of your child's health habits and pring these questions!					
1. What is	the reason for this visit?							
2. Please	list any known health conditions that		d with:					
3. List any	3. List any medications your child is currently taking, or has taken in the past.							
4. Please	4. Please indicate any history of antibiotic use, listing when, what, and for what purpose.							
5. Are the	re any known drug allergies?							
6. List sup	plements, herbs, remedies, including	athletic performance supplem	nents that your child is currently taking:					
7. Do you	suspect your child to use recreationa	Il drugs? If so, what:						
8. List any	8. List any hospital procedures/surgeries that your child has had:							

1. Does your child consume any of the following?							
Soda	none	< 2 ca	ns / day		> 2 cans / day		
Sweets / Carbs	none	< twice	< twice / day		> twice / day		
White Flour	none	< twice	< twice / day		> twice / day		
Milk/Dairy Products	none	< twice	< twice / day		> twice / day		
Juice	none	< twice	e / day		> twice / day		
Meat/Fish	none	rarely	,	< once	e a week	every day	
2. How much water does your child drink each day?							
3. Are there smokers in the child's home? Yes No							
4. Does your child get consistent physical activity? Yes No							
5. Please list any regular exercise or sports that your child participates in:							

History (please fill in or circle the appropriate answer)						
1. Did your child have colic as an infant? Yes No						
2. How was your child fed as an infant? Breast Bottle						
What brand / kind of formula?						
3. Has your child had any respiratory infections? Yes No						
How often?						
4. Does your child ever complain of back or neck pain? Yes No						
Please explain:						
5. Does your child ever complain of arm or leg pain? Yes No						
Please explain:						
6. Does your child ever complain of headaches? Yes No						
How often?						
7. Has your child had ear infections? Yes No						
Age of the first occurrence and frequency:						
8. Do they typically occur in the same ear? Yes No Which ear? Right Left Bo	th					
9. Please list any illnesses that your child has had and approximate dates of occurrence:						
10. Has your child been vaccinated? Yes No Recently? Yes No						
11. Please describe any reactions that your child has had to past or recent vaccinations:						
12. Please list any other concerns you have regarding your child's health:						

Sleep Habits (please fill in or circle the appropriate answer)							
1. How well does	1. How well does your child sleep?						
Well	Well Trouble falling asleep		Trouble stag	ying asleep	Insomnia		
2. Does your child wake up tired?			es No				
3. How many hours does your child sleep on an average night?							
4. Does your child	I take naps? Yes	No					
5. Does your child	have nightmares?	No	Sometimes	Often			

For Cycling Females Only (please fill in or circle the appropriate answer)							
1. Age of onset of menarche (first period):							
Approximate Date:							
2. Is your child currently using any method of birth control? Yes No							
What kind? Oral Pill Injected Patch Ring							
3. How long has your child been using birth control?							
4. Please describe any symptoms that your child may have experienced while using birth control (i.e. yeast							
infections, heavy / light bleeding, moodiness, weight gain, acne, sweet cravings, palpitations, fatigue):							
5. First day of last period:							
6. Length of typical period:							
7. Is menstrual cycle regular? Yes No Not Always							
Details:							
o. Now many paus and / or tampons (please circle) are used on neavy days:							
9. Any knowledge of passing clots? Yes No How often?							
10. Any spotting between periods? Yes No At what point in cycle?							
11. Does your child experience cramping? None Mild Moderate Severe At what point in the cycle?							

INSTRUCTIONS: Please mark the following symptoms as they apply. Please be as detailed as possible.

Low Mood	SIGNS & SYMPTOMS	Mild	MODERATE	More Information
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	Cold Sores		1	
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