YOUTH HEALTH HISTORY QUESTIONNAIRE

Name _____ Today's date: _____

Age: _____ Birth Date: _____ Weight: _____ Height: _____

This questionnaire is designed to assist in providing a general overview of your child's health habits and history. Please be as detailed as possible when answering these questions!

1. What is the reason for this visit?

_____

_____

_____

2. Please list any known health conditions that your child has been diagnosed with:

_____

_____

_____

3. List any **medications** your child is currently taking, or has taken in the past.

_____

_____

4. Please indicate any history of **antibiotic** use, listing when, what, and for what purpose.

_____

_____

5. Are there any known drug allergies?

_____

6. List supplements, herbs, remedies, including athletic performance supplements that your child is currently taking:

_____

_____

7. Do you suspect your child to use recreational drugs? If so, what:

_____

8. List any hospital procedures/surgeries that your child has had:

_____

_____

_____

_____

LIFESTYLE INDICATORS (please fill in or circle the appropriate answer)

1. Does your child consume any of the following?

Soda	none	< 2 cans / day	> 2 cans / day	
Sweets / Carbs	none	< twice / day	> twice / day	
White Flour	none	< twice / day	> twice / day	
Milk/Dairy Products	none	< twice / day	> twice / day	
Juice	none	< twice / day	> twice / day	
Meat/Fish	none	rarely	< once 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 Both
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 your child sleep?

   Well Trouble falling asleep Trouble staying asleep Insomnia

2. Does your child wake up tired? Yes No

3. How many hours does your child sleep on an average night? _____

4. Does your child 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: _____

8. How many pads and / or tampons (please circle) are used on heavy 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.

SIGNS & SYMPTOMS	MILD	MODERATE	SEVERE	MORE INFORMATION
Low Mood				
Lowered Self-Esteem				
Discouragement				
Sadness / Crying				
Reserved / Withdrawn				
Decreased Interest in Activities				
Decreased Initiative / Motivation				
Behavior Problems				
Aggression				
Anger				
Anxiety				
Fear				
Difficulty Concentrating				
Foggy Thinking				
Memory Problems				
Constant Hunger				
Never Hungry / Anorexia				
Weight Loss				
Weight gain				
Decrease in Strength / Stamina				
Decrease in Athletic Performance				
Fatigue				
Anemia				
Headaches / Migraines				
Body / Joint / Backaches				
Digestive Problems				
Irritable Bowel				
Constipation				
Loose Stool / Diarrhea				
Bloating				
Frequent Urination				
Bedwetting				
Allergies				
Asthma				
Throat Clearing				
Excessive Mucous / Runny Nose				
Dry Skin				
Acne				
Cold Sores				
Infections / Lowered Immunity				