

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? _____