CCMHS – CHILD/ADOLESCENT HEALTH HISTORY QUESTIONNAIRE

Name: _____ Age _____ Date: _____

Physician Information: Date of last complete physical exam: _____

Family Physician: _____ Date of last visit: _____

Pediatrician: _____ Date of last visit: _____

Specialist(s): _____ Date of last visit: _____

Immunization Status: Has the child received the required immunizations? Yes ☐ No ☐

If no, please explain: _____

Current Medications: Is the child currently on any prescription medication? Yes ☐ No ☐

If yes, please describe:

_____ Dosage: _____ Frequency: _____

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Does the child frequently use over the counter medications (Tylenol, aspirin, antacids, cold/allergy medications, laxatives)? Yes ☐ No ☐

If yes, please describe:

_____ Symptoms: _____ Dosage/Frequency: _____

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Health Status:

1. Is the child being treated for any long-term problem? Yes ☐ No ☐
   If yes, please describe: _____
2. Has the child ever been hospitalized for a medical problem? Yes ☐ No ☐
   If yes, please describe: _____
3. Has the child been treated for sickness or injury during the past year? Yes ☐ No ☐
   If yes, please describe: _____
4. Does the child **often** complain of, or exhibit, any of the following? Check those that apply.

☐ headache	☐ sore throat	☐ stomachache
☐ dizziness	☐ coughing	☐ heartburn
☐ muscle twitching	☐ difficulty breathing	☐ diarrhea
☐ bedwetting	☐ earache	☐ constipation
☐ vision problems	☐ hoarseness	☐ vomiting
☐ hearing problems	☐ bleeding gums	☐ poor appetite

5. Please describe the child's eating habits/patterns: _____
6. Please describe the child's sleeping habits (bedtime, wake-up time, naps): _____
7. Does the child use any illegal substances (tobacco, alcohol, street drugs)? Yes ☐ No ☐
   If yes, please explain: _____

Allergies:

List any allergies or drug sensitivities your child has or has had in the past. _____

Summary of Findings: _____

Recommendations: _____

Reviewed by: _____ Date: _____

Signature/Credentials