SHAHLA HESHMATI, M.D., INC.

HEALTH QUESTIONNAIRE

Last Name: ______________________ **First Name:** ______________________ **Date of Birth:** ____________

Please check* ☐*Y for yes or* ☐N for *no, and circle or explain where required. Write N/A for questions that are not applicable.

Reason for today's visit:____

Previous medical care: Dr. ______________________ Dental Care: ☐Y ☐N Eye Exam: ☐Y ☐N

PREGNANCY & BIRTH Mother's age at pregnancy? ____________

Any illness during pregnancy? ☐Y ☐N ____________

Medications during pregnancy? ☐Y ☐N ____________

(exclude vitamins & iron) ____________

Smoking - alcohol - street drugs - during pregnancy? ____________

Was baby early - late - on time? ____________

Type of delivery? ____________ Birth Weight ________ Length ________

Complications? ☐Y ☐N ____________ Apgar ________

Problems with baby at birth? Breathing ☐Y ☐N Jaundice ☐Y ☐N

Other ____________

Problems soon after? Nursery or home? ____________

PAST MEDICAL HISTORY Allergic Reactions? Medicine ☐Y ☐N Food ☐Y ☐N Animals ☐Y ☐N

Insect bites ☐Y ☐N ____________

Medications taken regularly? (exclude vitamins) ____________

____

Immunizations - up to date? ☐Y ☐N Do you have a record? ☐Y ☐N

Hospitalizations (when - where - why?) ____________

____

Serious injuries (when - where?) ____________

____

Measles	☐Y ☐N	Mumps	☐Y ☐N	German Measles (3 day)	☐Y ☐N
Chicken Pox	☐Y ☐N	Whooping Cough	☐Y ☐N	Rheumatic Fever	☐Y ☐N
Scarlet Fever	☐Y ☐N	Ear Infections	☐Y ☐N	Strep Throat	☐Y ☐N
Asthma/Wheezing	☐Y ☐N	Eczema/Hives	☐Y ☐N	Seizures	☐Y ☐N
Anemia	☐Y ☐N	Hepatitis	☐Y ☐N	Hearing Problems	☐Y ☐N
Bleeding Tendency	☐Y ☐N	Urinary Infections	☐Y ☐N	Vision Problems	☐Y ☐N
Blood Transfusions	☐Y ☐N	Joint Problems	☐Y ☐N	Other:	

FAMILY MEDICAL HISTORY List all blood relatives of your child who have had the following problems. Use (F) for Father, (M) for Mother, (B) Brother, (S) Sister, (MM) Mother's Mother, (MF) Mother's Father, (FM) Father's Mother, (FF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin:

Anemia/Blood Disease ____________

Asthma ____________

Mental Retardation ____________

Drug Problem ____________

Alcoholism ____________

Cancer ____________

Aids ____________

Cystic Fibrosis ____________

Muscular Dystrophy ____________

Tuberculosis ____________

Arthritis ____________

Epilepsy/Seizures ____________

Heart Disease ____________

High Blood Pressure ____________

Cholesterol Problem ____________

Migraine ____________

Sudden Infant Death ____________

Birth Defects ____________

Early Deafness ____________

Diabetes ____________

FEEDING & NUTRITION Food Allergies: ____________

Appetite usually Good? ☐Y ☐N

Colic or feeding problems during the first three months? ☐Y ☐N

Breast fed? ☐Y ☐N Number of months? ☐Y ☐N

Formula? ☐Y ☐N Current brand? ____________

Vitamins? ☐Y ☐N Current brand? ____________ Fluoride? ☐Y ☐N

Special diet? ☐Y ☐N ____________

DEVELOPMENT & BEHAVIOR

Grade in school ____________

Problems in school? ☐Y ☐N

____

Learning problems? ☐Y ☐N ____________

Behavior problems? ☐Y ☐N ____________

Bad Habits ____________

Bed wetting? ☐Y ☐N

FAMILY PROFILE Parents: Married Separated Divorced

Father's age? ________ Highest school grade? ________ Health? ________

Mother's age? ________ Highest school grade? ________ Health? ________

List child's brothers, sisters, and their ages: ____________

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