



# Health History Questionnaire

Patient Label

**Name and relationship of person filling out this form:**

Mother    Father    Legal Guardian    Other:

**Were you referred by your OB?**    No    Yes, (please list name)

**How did you hear about our practice?**

**Does the patient have allergies to medication, food and/or other?**    No    Yes, (please list)

**Has the patient been treated or diagnosed with any medical problems?** (e.g., speech or development delay, wheezing, broken bones, surgeries, etc.)

No    Yes (please list)

**Is the patient taking any medication?** (including over-the-counter supplements and vitamins)

No    Yes, please list medication(s)

**Are there any significant medical family histories?** (e.g., heart disease before age 50, wheezing, allergies, other hereditary illnesses, etc.)

No    Yes, (please list)

**Is your child up-to-date with routine vaccines?**    No    Yes    I don't know