SCHAEFER/CLINI-REC® PEDIATRIC HEALTH HISTORY QUESTIONNAIRE TO YOUNG ADULTHOOD

Identification Information: Today's Date______

Patient's Name______ Male____ Female____ Date of Birth______ Age ____Yrs. ____Mos.

Parent or Guardian's Name ______

Address:______ Telephone:______

A. REASON FOR VISIT

1. Comprehensive periodic examination ____Yes ____No
2. Medical problem(s): Please list. About when did they begin? What concerns you most? ______

______

______

______

3. If patient is, or has been, treated for any other illnesses or medical problems by other physicians, please describe the problems and write the name of the physician or medical facility treating him/her.

Illness or Medical Problem	Physician or Medical Facility	Telephone Number

CURRENT OR PAST HEALTH HISTORY

Please _✓_ the appropriate answer unless otherwise specified. If in doubt about the question, please circle it. Your doctor or nurse will review your answers with you.

____ Parent Completing: Does your child have or ever had any of the following?

____ Patient Completing: Do you have or ever had any or the following?

EYES

1. Crossed or wandering eyes? ____No ____Yes
2. Vision changes past year? ____No ____Yes
3. Wear glasses or contact lenses? ____No ____Yes
4. Eye muscle surgery? ____No ____Yes
5. Trouble reading or watching TV? ____No ____Yes

EARS

6. Repeated infections? ____No ____Yes
7. Chronic drainage? ____No ____Yes
8. Ear tubes? ____No ____Yes
9. Speech problems or speech delay? ____No ____Yes
10. Deafness or decreased hearing? ____No ____Yes

NOSE AND THROAT

11. Trouble breathing through the nose? ____No ____Yes
12. Frequent colds? ____No ____Yes
13. Nose allergy symptoms? Itchy nose? ____No ____Yes
14. Nose bleeds? ____No ____Yes
15. Frequent sore or strep throat infections? ____No ____Yes
16. Still have your tonsils? ____No ____Yes

TEETH

17. Decay or defects? ____No ____Yes
18. Bite (occlusion) defects? ____No ____Yes
19. Date of last visit to Dentist? ______

    to Orthodontist? ______

SKIN

20. Birthmarks or moles? ____No ____Yes
21. Acne? ____No ____Yes
22. Heavy tan or often sunburned? ____No ____Yes

CHEST

23. Chronic cough? ____No ____Yes
24. Short of breath with activity? ____No ____Yes
25. Wheezing with exercise? ____No ____Yes
26. Asthma/hay fever? ____No ____Yes
27. Pneumonia? ____No ____Yes
28. Tuberculosis skin test change? ____No ____Yes

HEART

29. Heart murmur? ____No ____Yes
30. Heart beats too fast? ____No ____Yes
31. Palpitations or irregular heart beat? ____No ____Yes
32. Pain over the heart? ____No ____Yes
33. Chest or shoulder pain with activity? ____No ____Yes
34. High blood pressure? ____No ____Yes
35. Blood cholesterol test done? ____No ____Yes

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BLOOD

36. Anemia? .... ____No ____Yes
37. Bleeding or easy bruising problems? ____No ____Yes
38. Clotting problems? (Hemophilia?). ____No ____Yes

DIGESTIVE TRACT

39. Chronic or frequent diarrhea? .... ____No ____Yes
40. Constipation?................................ ____No ____Yes
41. Recurrent vomiting? .... ____No ____Yes
42. Recurrent abdominal pain? .... ____No ____Yes
43. Bloody bowel movements? .... ____No ____Yes
44. Jaundice or yellow skin? .... ____No ____Yes
45. Prolonged loss of appetite?............ ____No ____Yes
46. Overeating followed by vomiting? .. ____No ____Yes

URINARY TRACT

47. Bed wetting problems?.................. ____No ____Yes
48. Infection one or more times?.......... ____No ____Yes
49. Bloody or dark colored urine? .... ____No ____Yes
50. Difficulty starting or stopping the stream?.................................. ____No ____Yes
51. Painful or frequent urination? .... ____No ____Yes

MUSCULO-SKELETAL

52. Limb or growing pains? .... ____No ____Yes
53. Painful or swollen joints?............... ____No ____Yes
54. Problems with muscle coordination or strength? .... ____No ____Yes
55. Posture problems? .... ____No ____Yes
56. Foot or ankle problems?................ ____No ____Yes
57. Severe back pain?........................ ____No ____Yes
58. Scoliosis/abnormal curve of back?.. ____No ____Yes
59. Lump or swelling of any bone? ...... ____No ____Yes

NEUROLOGICAL

60. Headaches? .... ____No ____Yes
61. Any fatigue or listlessness?........... ____No ____Yes
62. Any dizziness?.............................. ____No ____Yes
63. Any loss of balance? .... ____No ____Yes
64. Convulsion, seizure, or fit?............ ____No ____Yes
65. Difficulty controlling use of hands, arms, or legs?.............................. ____No ____Yes

GENERAL

66. Recent weight loss? Or gain?... ____No ____Yes
67. Too short? Too tall? .... ____No ____Yes
68. Too fat? Too thin?.. ____No ____Yes
69. Easy tiring or fatigability? .... ____No ____Yes
70. Heavy or excessive appetite? .... ____No ____Yes
71. Trouble sleeping? .... ____No ____Yes

CHILDHOOD DISEASES

72. Whooping cough?.......................... ____No ____Yes
73. Chicken Pox? .... ____No ____Yes
74. Measles? .... ____No ____Yes
75. Rubella (3-day measles)? .... ____No ____Yes
76. Mumps?... ____No ____Yes
77. Polio?... ____No ____Yes
78. Kawasaki Disease? .... ____No ____Yes

PUBERTY

BOYS ONLY: Approx. age of onset

79. Voice change?............................ ____Yrs. ____Mos.
80. Muscular growth?........................ ____Yrs. ____Mos.
81. Axillary hair present?.................... ____Yrs. ____Mos.
82. Pubic hair present? .... ____Yrs. ____Mos.
83. Testes growing? .... ____Yrs. ____Mos.
84. Penis growing?............................ ____Yrs. ____Mos.
85. Swollen painful breast(s)?........... ____Yrs. ____Mos.
86. Interest in girls?.......................... ____Yrs. ____Mos.

GIRLS ONLY: Approx. age of onset

87. Breasts developing?..................... ____Yrs. ____Mos.
88. Menstrual periods present?.......... ____Yrs. ____Mos.
89. Age & date of first menstrual period ____________________________
90. Regular periods? .... ____No ____Yes
91. Pain or discomfort with period?.. ____No ____Yes
92. Heavy flow? .... ____No ____Yes
    Scant flow? .... ____No ____Yes
93. Use? .... ____Tampons ____Pads ____Both

94. ARE YOU PHYSICALLY HANDICAPPED OR LIMITED IN ANY WAY? .... ____No ____Yes

If Yes, please name or describe: ____________________________

95. DO YOU HAVE ANY QUESTIONS OR CONCERNS TO DISCUSS WITH YOUR DOCTOR? .... ____No ____Yes

SUMMARY OF QUESTIONNAIRE

(By Nurse or Doctor)

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