Health Questionnaire

Name: _____ **DOB:** _____ **Date:** _____

Please complete this health survey before the doctor sees you for your checkup. The "you" in the following questions refers to the patient being examined.

IF YOU MARK YES ON ANY OF THESE QUESTIONS, PLEASE LIST DETAILS ON THE LINE PROVIDED.

Have you been hospitalized or had any outpatient surgery since your last checkup? □ Yes □ No _____

_____

Are you seeing any other physicians or therapists at the present time? □ Yes □ No _____

_____

List any medications you are taking regularly. _____

_____

Have you developed any new food or medication allergies? □ Yes □ No _____

_____

Have there been any deaths or new serious illnesses in your family? □ Yes □ No _____

_____

Have there been any changes in your household makeup? □ Yes □ No _____

_____

Have you had any injuries in the last two years? □ Yes □ No _____

_____

Have you had the Chicken Pox? □ Yes □ No _____

What do you do for exercise on a regular basis? _____

How many hours do you sleep at night? _____ **Is your overall energy level good?** □ Yes □ No

How is your appetite? _____ **Are you on a special diet?** □ Yes □ No

Would you like to weigh more? □ Yes □ No **Would you like to weigh less?** □ Yes □ No

Are you exhibiting any of these issues or symptoms?

Problems in school?	□ Yes	□ No	Frequent headaches?	□ Yes	□ No
Ear or hearing problems?	□ Yes	□ No	Eye or vision problems?	□ Yes	□ No
Nasal congestion or nosebleeds?	□ Yes	□ No	Chest pain?	□ Yes	□ No
Asthma?	□ Yes	□ No	Frequent cough or shortness of breath?	□ Yes	□ No
Anemia or bleeding problems?	□ Yes	□ No	Palpitations?	□ Yes	□ No
Nausea, vomiting, heartburn?	□ Yes	□ No	Abdominal pain?	□ Yes	□ No
Convulsion or spells of any kind?	□ Yes	□ No	Diarrhea or constipation?	□ Yes	□ No
Pain with urination?	□ Yes	□ No	Frequent or urgent urination?	□ Yes	□ No
Bedwetting?	□ Yes	□ No	Rashes or itching?	□ Yes	□ No
Any vaginal or urethral discharge?	□ Yes	□ No	Swelling or lumps anywhere?	□ Yes	□ No
Emotional problems?	□ Yes	□ No			

If you marked yes on any of these questions, please explain on the back side of this form.

GIRLS ONLY:

Have your periods started? □ Yes □ No **If yes, please answer the following questions:**

Are they regular or irregular? □ Regular □ Irregular **Is your flow heavy or normal?** □ Heavy □ Normal

TULSA PEDIATRIC GROUP, PC
6465 S Yale Ave, Suite 715 | Tulsa, OK 74136 | Tel (918) 481-4750 | Fax (918) 481-4755
www.tulsapediatricgroup.com