JASPER MOUNTAIN
Hope for Children & Families

MEDICAL HISTORY QUESTIONNAIRE

Child's Name: _____ **Birth Date:** _____

Person Completing Form: _____

Relationship to Child: _____

Date Questionnaire was Completed: _____

1. General Medical History

Please describe significant health issues below:

Pre natal and natal history: _____

_____

_____

Childhood illnesses (including communicable diseases such as chicken pox): _____

_____

_____

_____

Major injuries/date:_____

_____

_____

Surgeries/Procedures: _____

_____

_____

Hospitalizations (medical, surgical or psychiatric): _____

_____

_____

Dietary Preferences/Issues: _____

_____

_____

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Please check if the child has had any of the following:

- ☐ Anemia
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chicken Pox
- ☐ Hepatitis
- ☐ Measles (10 day)
- ☐ Measles, rubella (3 day)
- ☐ Mumps
- ☐ Rheumatic fever
- ☐ Pneumonia
- ☐ Whooping cough
- ☐ Childhood onset diabetes
- ☐ Other:

_____

General

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Mood swings
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweating
- ☐ Tiredness
- ☐ Weight loss/gain

Cardiovascular

- ☐ Breathing problems
- ☐ Chest pain
- ☐ Irregular heart beat

Eyes

- ☐ Crossed/wandering
- ☐ Eye irritation
- ☐ Headaches
- ☐ Vision problems:

_____

Skin

- ☐ Bruise easily
- ☐ Change in moles
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

Gastrointestinal

- ☐ Appetite poor
- ☐ Bloody or dark stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomachaches
- ☐ Vomiting
- ☐ Worms

Dental

- ☐ Bleeding gums
- ☐ Grinding teeth
- ☐ Sensitivity to hot/cold
- ☐ Thumb-sucking
- ☐ Toothaches

Genito-Urinary

- ☐ Bed wetting
- ☐ Daytime wetting
- ☐ Blood in urine
- ☐ Genito-urinary rash
- ☐ Discharge from vagina or penis
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Unusual urine odor

Muscle/Joint/Bone

- ☐ Broken bones or sprains
- ☐ Coordination problems
- ☐ Posture problems
- ☐ Pain, weakness or swelling in (circle area):
  Arms Hips Back
  Legs Feet Neck
  Hands Shoulders

Nose/Throat/Chest

- ☐ Difficulty breathing
- ☐ Difficulty swallowing
- ☐ Frequent colds
- ☐ Horseness
- ☐ Mouth-breathing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Sinus problems
- ☐ Sore throats
- ☐ Strep throat
- ☐ Tonsil infections
- ☐ Wheezing

Hearing/Speech

- ☐ Difficulty hearing
- ☐ Earaches
- ☐ Ear infections
- ☐ Hoarseness
- ☐ Speech problems

Currently, does the child have any untreated or residual medical condition which requires further evaluation or need for physician consultation?: _____

_____

_____

_____

_____

2. Allergies (please include drug, food, seasonal, animal or other allergies):

Drug or Allergen	Type of Reaction	Treatment

3. Medical/Dental/Vision Provider History

Medical Child's current primary care physician: _____

Last exam date: _____ Provider & location: _____

Other physicians who have see the child (names, locations): _____

_____

_____

Dental Please list child's last dental exam and provider.

Exam date: _____ Provider & location: _____

Vision Does the child wear glasses? ☐ Yes ☐ No ☐ Reading Only

Please list the child's last vision exam and provider.

Exam date: _____ Provider & location: _____

Psychiatric Is the child currently being seen by a psychiatrist? ☐ Yes ☐ No

Name of Psychiatrist: _____

Contact Information: _____

Length of time being seen by this psychiatrist: _____

4. Medications at Admission

Is this child currently taking medications? ☐ Yes *(If yes, please provide details below.)* ☐ No

Medication	Dosage & Schedule	Behavior/Condition	Date Started

5. Psychotropic Medication History

List all psychotropic medications that this child has been prescribed in the past, the behavior targeted, any allergic/adverse reactions, and any other reason for discontinuation.

Medication	Behavior/condition targeted.	Adverse reaction/reason for discontinuation.	Duration

6. Other Information

Immunization Status: _____

Immunization Record (photocopy) provided to Jasper Mountain: ☐ Yes ☐ No

Birth Certificate (certified copy) provided to Jasper Mountain: ☐ Yes ☐ No

Social Security Card (photocopy—or SS#) provided to Jasper Mountain: ☐ Yes ☐ No

7. Family History

Health Issue	Father	Mother	Father's Parents	Mother's Parents	Siblings
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Asthma/Allergies	☐	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐	☐
ALS	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐
Alcolholism	☐	☐	☐	☐	☐
TB	☐	☐	☐	☐	☐
Comments:					