Family Health Center of Ashland City, 342 Frey Street, Ashland City, TN 37015, 615-792-1199
Scott Brown, MD; Travis Shivers, MD
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**HEALTH QUESTIONNAIRE For Patient Name: _____Birthdate: _____**
Information is self-reported by patient (parent). Answer questions for the child who is getting services today.

**Child's Medical History (Please check all that apply)**

| | | | |
|---|---|---|---|
| Anemia | Diabetes | HIV/AIDS | Sexually Transmitted Disease |
| Asthma | Ear Tubes | Kidney/Bladder | Sexual Problems |
| Attention Deficit Disorder | Epilepsy/Seizures | Liver Disease/Hepatitis | Skin Problem |
| Birth Defects | Hearing Impaired | Mental Illness | Childhood Diseases |
| Colon/Bowel | Heart Murmur | Migraine Headaches | Tuberculosis |
| Depression | High Blood Pressure | Premature (less than 36 weeks) | Vision Problems |

Any other medical problems: _____
Hospitalizations/ Surgeries: _____
Chronic Medications: _____
Allergies: _____
Wear seat belt/car seat Smoke detector Regular exercise Guns unloaded and out of child's reach
Exposure to 2nd hand smoke in the home Exposure to 2nd hand smoke in the car
Public Water Supply: (Name)_____ Other Water Supply

**For Children under 6 Years of Age:**
Birth Weight: _____ Birth Length: _____ Length of Hospital Stay: _____
Hospital of Birth: _____ Mother's Number of Prenatal Visits: _____
Pregnancy Complications Delivery Complications C-section
Attends Day Care: (Name)_____
List any Childhood Diseases: _____

When was child's last complete check-up (physical exam, blood tests)? _____

**Family Medical History of Patient (Include parents, grandparents, brothers, sisters)**

| | Father | Mother | Father Parent | Mother Parent | Brother Sister | | Father | Mother | Father Parent | Mother Parent | Brother Sister |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer | | | | | | Kidney Disease | | | | | |
| Diabetes | | | | | | Glaucoma | | | | | |
| Heart Disease | | | | | | Bleeding disorders | | | | | |
| Stroke | | | | | | Mental Illness | | | | | |
| High blood Pressure | | | | | | Epilepsy/Seizures | | | | | |
| Other | | | | | | | | | | | |

**Questionnaire reviewed and appropriate health education provided**
**Date_____ Staff signature/Title _____**