Center for Family Health

Northeast Health Center ● 1024 Fleming St ● 787-4361
Parkside Health Center ● 2400 Fourth St ● 788-6812
Jackson High Health Center ● 544 Wildwood ● 780-0838
Northwest Community Health Center ● 6700 Rives Junction Road ● 569-3200

Health History Questionnaire

Print Mother/Guardian Date of Birth		Print Father/Guardian Date of Birth
Address		Phone Number
Primary Insurance:	ID Number:	Subscriber Name and DOB:
Secondary Insurance:	ID Number:	Subscriber Name and DOB:

MEDICATIONS			
Current Medications:	Dose:	How Often:	Pharmacy:

PAST MEDICAL HISTORY – Please check any that apply to your child

□ Bee Sting Allergies	□ Sleep Apnea	□ Frequent Sore Throats	□ Eczema
□ Food Allergies Type:	□ Bed Wetting	□ Headaches	□ Hives/Rash
□ Hay Fever	□ Frequent Urination	□ Hearing problems	□ Warts
□ Latex Allergy	□ Frequent Urine Infections	□ Nosebleeds	□ HIV
□ Medication Allergy	□ Kidney or Bladder Problems	□ Vision Problems	□ MRSA
□ Pet Allergies	□ ADD/ADHD	Glasses? □ Yes □ No	□ RSV
□ Other Allergies Type:	□ Anxiety	□ Broken Bone	□ Constipation
□ Heart Murmur	□ Cutting Behavior	Part of body?	□ Diarrhea
□ High Blood Pressure	□ Depression	□ Pain in Joints	□ Stomach Pain
□ Asthma	□ Eating Disorder	□ Anemia	□ Diabetes
□ Breathing Treatments	□ Seizures	□ Cancer Type:	□ Other:
Machine at home? □ Yes □ No	□ Frequent Ear Infections	□ Sickle Cell Disease	
□ Shortness of Breath	Tubes? □ Yes □ No	□ Acne	

FAMILY HISTORY – Please check if any of the child's family members (mother, father, siblings, other relatives) have ever had any of the following:

□ Family History Unknown – Patient Adopted

Condition:	Who:	Condition:	Who:	Condition:	Who:
□ Anxiety		□ Hearing Loss		□ Renal/Kidney Disease	
□ Asthma		□ High Cholesterol		□ Seizure Disorder	
□ Alcoholism		□ High Blood Pressure		□ Sickle Cell Disease	
□ Blood Disease		□ Learning Disability		□ Stroke	
□ Heart Disease		□ Mental Illness		□ Substance abuse	
□ Cancer		□ Migraines		□ Thyroid Disease	
□ Depression		□ Obesity		□ Tuberculosis	
□ Diabetes				□ Other	

Deceased:	Cause of Death:	Age at Death:
□ Patient Mother	Mother_____	Mother_____
□ Patient Father	Father_____	Father_____
□ Patient Sister	Sister_____	Sister_____
□ Patient Brother	Brother_____	Brother_____

Provider Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

Note: In accordance with Michigan legal requirements, parental consent is not required for outpatient mental health services for individuals age 14 and older, for minors to receive a diagnosis/ medical treatment for a venereal disease or HIV, or a diagnosis of pregnancy or related prenatal care. These services are in accordance with MCLA (Michigan Complied Laws Annotated) 333.9132, 333.5127, 333.1707