Fantasy

Health questionnaire

Dear parents!

Please, take some time to fill in this questionnaire. The information you provide is essential for an adequate and safe treatment of your child.

The child's Last name, First name, and Patronymic: _____

_____

The child's date of birth _____

1. Did you have any complications during the pregnancy?

If yes, which ones _____

2. Did you have any complications during the labor and delivery?

If yes, which ones _____

3. Did the child have any serious diseases during the 1st year of his/her life?

If yes, which ones _____

4. Has your child been vaccinated?

- ☐ Yes, according to the calendar.
- ☐ Yes, according to the individual schedule.
- ☐ No

5. Does your child have or did he/she have any of these diseases/conditions:

- ☐ Gastrointestinal tract disorders
- ☐ Heart disorders
- ☐ Kidney disorders
- ☐ Endocrine system disorders
- ☐ Blood disorders
- ☐ Respiratory tract disorders
- ☐ Nervous system disorders

6. Which infectious diseases (measles, chicken pox, scarlatina, and others) did your child have? _____

_____

7. Did the child have any traumas/operations/hospitalizations?

If yes, which ones: _____

8. Is your child currently taking any medications?

If yes, which ones: _____

9. Have your child had any allergic reactions?

If yes:

a. What causes the allergy _____

b. How does it appear (redness, rash, itch, edema, watering eyes, anaphylactic shock, etc.) or

_____

c. Date and time of the last allergic reaction:_____

10. I would like to add the following about my child's health:

_____

_____

_____

E-mail: _____

Mobile phone: _____

Date _____ Signature_____ / _____/

Patient record number (filled in by the clinic's staff) _____