Medical Questionnaire

Child's Name ..... (Male / Female)

Date of Birth ..... Age .....

Adress .....

Phone .....

Nationality .....

Language .....

1.What are your child's symptoms?

☐ fever ☐ cough ☐ sore throat ☐ runny nose

☐ abdominal pain ☐ vomiting ☐ nausea ☐ diarrhea ☐ bloody stool

☐ loss of appetite ☐ inactive ☐ irritable ☐ headache ☐ rash

☐ swelling ☐ others（ ）

2. How long has your child had these problems?

Since .....

3.What illness has your child had in the past?

☐ asthma ☐ atopic dermatitis ☐ seizures ☐ Kawasaki disease

☐ Others（ ）

4.Has your child ever had any operations?

☐Yes （ ） ☐No

5.Is your child taking any medication?

☐Yes （ ） ☐No

6.Does your child have any food or medication allergies?

☐Yes （ ） ☐No

7.How was the delivery?

birth weight ..... g Maternal age at time of pregnancy .....

☐ natural delivery ☐ vacuum delivery ☐ Caesarean section

8.Vaccination（Check your child has received so far)

☐ Hib ☐ Pneumococcus ☐ DPT-IPV ☐ hepatitis B ☐ Rotavirus

☐ BCG ☐ MR ☐ chicken pox ☐ Mumps ☐ Japanese Encephalitis

☐ Others

9.What kind of medicine can your child take?

☐ syrup ☐ powder ☐ tablet ☐ capsule

Hanamomo Pediatric Clinic