Dr. Stephen C. Gangemi
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HEALTH QUESTIONAIRE

Personal Information

Child's full name: _____ Name they wish to be called: _____

Street Address _____

City _____ State _____ Zip _____

Phone: H) _____ W) _____ E-Mail:_____

Date of birth _____/_____/_____ Gender: M / F Health Insurance Company: _____

Who were you referred by? _____

Name of parent/guardian: _____ Phone: _____

I, _____, read and understood Dr. Gangemi's Office Policies sheet regarding appointments, fees, billing, and emergencies, and have had all my questions and concerns answered.

Signature of parent/guardian _____ Date _____/_____/_____

Primary Concern

What brings you to my office? _____

_____

Date you noticed original problem: _____

Was there an event that created the problem? _____

Has the child had this or similar conditions in the past?_____

What makes your child better? _____ Worse? _____

Is the issue(s) getting worse? _____ Constant? _____ Worse at a certain time of day? _____

Is this problem interfering with School? _____ Sleep? _____ Activity? _____ Other? _____

Please list your goals for treatment, both immediate and future: _____

_____

_____

_____

Health History

List all current health issues & problems: _____

_____

List other practitioners seen, treatments, self-care activities, and results: _____

_____

List any illness they have had not previously mentioned, if any: _____

_____

List all surgeries they have had, with dates and results: _____

_____

Have they ever been in an accident or seriously injured? (If so, please describe) _____

_____

Are there any dental or TMJ problems? _____

List all medications, vitamins, herbs, and other supplements they are now taking: _____

_____

_____

List all medications and other substances (i.e.: foods) to which they are allergic: _____

_____

Family History

Please list age(s) and health problems (if any); if deceased, please list age at death and cause of death:

Father _____ Mother _____ Sisters _____

Grandparents _____ Brothers _____

General

*How many hours per night do they sleep? _____ *Do they fall right asleep? **Y** **N** *Do they wake up feeling refreshed? **Y** **N**
*Do they sleep through the night without awaking? **Y** **N** *Do they remember their dreams? **Y** **N** **Unsure**
*Do they have night sweats? **Y** **N** *Nightmares? **Y** **N**

Vaccines

Please mark the vaccines, if any, your child has had with dates:

Hib _____ DtaP or DTP _____ Covid-19: _____
IPV _____ MMR _____ Other _____
Varicella _____ Hep. B _____

DIET HISTORY

How many (cups) do they drink each day: Water? _____ Milk? _____ Juice? _____ Caffeinated sodas/tea? _____ Diet Sodas? _____

List oils or fats that you use in cooking: _____

Do they frequently skip meals? **Y N**

Are they on any special diet or nutrition program? **NO YES (list)** _____

List the diets you have tried in the past with results:

1>_____

2>_____

3>_____

Are they allergic or sensitive to any foods? **Y N** If yes, name the foods and describe the problem. _____

_____

What foods do they dislike? _____

Circle the foods they crave: Meats Fats Sweets Salty foods Vegetables Fruits Breads Fatty foods
Spicy foods Sour foods Cereals Dairy Other individual: _____

*Do you use butter or margarine in your house? (circle)

*Do you know what partially hydrogenated fats are? **Y N** If yes, does your child eat them? **Y N**

What do they usually eat for **breakfast**? _____

What do they usually eat for **lunch**? _____

What do they usually eat for **dinner**? _____

What do they usually eat for **snacks** (in between meals and/or before bed)? _____

What foods do they eat a lot of (at least once a day, every day)? _____

How many bowel movements do they have per day? _____ Are the stools formed? **Y N**

Please list all lab work your child has had done and include a copy:

_____ _____ _____

Is there anything else you would like to tell me or feel that I should know? _____

_____

_____

_____