Oregon Center for Children and Youth with Special Health Needs

OCCYSHN

Community Connections Network

linking health, education and community services through a network of community-based teams

HEALTH QUESTIONNAIRE

Child's Name: _____ **DOB**: _____ **County**: _____

Date Completed: _____ **Person Completing**: _____

Primary Language: _____ **Relationship to Child**: _____

1. Yes ❑ No ❑ Is your child on a special diet?
   If yes, specify _____
2. Yes ❑ No ❑ Does your child require special feeding techniques or have difficulties with feeding (such as choking, gagging, coughing, vomiting, or slow to complete a meal)?
   If yes, specify: _____
3. Yes ❑ No ❑ Does your child have a history of neurological problems (such as seizures/epilepsy, muscle weakness, hydrocephalus or cerebral palsy)?
   If yes, explain: _____
4. Yes ❑ No ❑ Does your child have an orthopedic problem (such as scoliosis, hand or foot deformity, hip dislocation)?
   If yes, specify: _____
5. Yes ❑ No ❑ Does your child have a history of chronic illness (such as diabetes, asthma or kidney problem)?
   If yes, specify: _____
6. Yes ❑ No ❑ Has your child been hospitalized, had surgery or a serious injury?
   If yes, explain: _____
7. Yes ❑ No ❑ Does your child have a hearing problem or use a hearing aid?
   If yes, explain: _____
8. Yes ❑ No ❑ Does your child have vision problems or wear glasses?
   If yes, explain: _____
9. Yes ❑ No ❑ Does your child use adaptive equipment such as wheelchair, prone stander, or braces?
   If yes, specify: _____
10. Yes ❑ No ❑ Does your child need any other health treatments daily (such as gastrostomy feedings, intermittent catheterization)?
    If yes, specify: _____
11. Yes ❑ No ❑ List the medication(s) that your child takes: _____

What else do you think the doctor needs to know about your child? _____

_____

In Partnership with:

OREGON HEALTH & SCIENCE UNIVERSITY