Medical History Questionnaire

Date
Patient Name

Sex (circle one) M F	Date of Birth	Today's Date:
Form Completed By:	Informant (guardian, parent):	

CHILD'S MEDICAL HISTORY

Has your child ever had:		
Allergies (Food, Meds or Seasonal)	❑ No	❑ Yes
Acid reflux/heartburn	❑ No	❑ Yes
Anemia	❑ No	❑ Yes
Asthma/Wheezing	❑ No	❑ Yes
Asthma Action Plan	❑ No	❑ Yes
Bladder Infections / Kidney Disease	❑ No	❑ Yes
Bleeding Disorders/Hemophilia	❑ No	❑ Yes
Bone or Joint Injuries	❑ No	❑ Yes
Cancer	❑ No	❑ Yes
Chicken Pox (Year)	❑ No	❑ Yes
Dental Problems	❑ No	❑ Yes
Depression/Suicidal Thoughts	❑ No	❑ Yes
Diabetes	❑ No	❑ Yes
Eating Disorders (Bulimia / Anorexia)	❑ No	❑ Yes
Emotional Abuse/Sexual Abuse	❑ No	❑ Yes
Emotional/Behavioral/Psychiatric Problems	❑ No	❑ Yes
Frequent Ear Infections	❑ No	❑ Yes
Head Injury	❑ No	❑ Yes
Hearing Problems	❑ No	❑ Yes
Heart Defects/Disease	❑ No	❑ Yes
Hernia	❑ No	❑ Yes
High Blood Pressure	❑ No	❑ Yes
Language Delay / Speech Problems	❑ No	❑ Yes
Lead Poisoning	❑ No	❑ Yes
Learning Disabilities (Including ADD / ADHD)	❑ No	❑ Yes
Liver Disease/Hepatitis	❑ No	❑ Yes
Migraine Headaches	❑ No	❑ Yes
Mononucleosis	❑ No	❑ Yes
Obesity/Overweight	❑ No	❑ Yes
Physical Disabilities	❑ No	❑ Yes
Pneumonia	❑ No	❑ Yes
RSV	❑ No	❑ Yes
Seizures/Epilepsy	❑ No	❑ Yes
Sexually Transmitted Infections	❑ No	❑ Yes
Sinusitis	❑ No	❑ Yes
Skin Problems/Eczema/Hives	❑ No	❑ Yes
Specialty Doctors … Has Your Child Seen?	❑ No	❑ Yes
Who?		
TB/Lung Disease	❑ No	❑ Yes
Tonsillitis	❑ No	❑ Yes
Vision Problems	❑ No	❑ Yes
Wetting (Day / Night)	❑ No	❑ Yes

Other Concerns:

Current Medication(s): List:

Reviewed by: Date:

FAMILY MEDICAL HISTORY

Has any parent (P), grandparent (GP), aunt (A), uncle (U), sister (S), or brother (B) had:

Allergies (List)	❑ No	❑ Yes	Who?
Asthma/Wheezing	❑ No	❑ Yes	Who?
TB/Lung Disease	❑ No	❑ Yes	Who?
Cystic Fibrosis	❑ No	❑ Yes	Who?
HIV/AIDS	❑ No	❑ Yes	Who?
Heart Disease	❑ No	❑ Yes	Who?
Sudden Cardiac Death	❑ No	❑ Yes	Who?
High Blood Pressure/Stroke	❑ No	❑ Yes	Who?
High Cholesterol	❑ No	❑ Yes	Who?
Blood Disorders			
Anemia	❑ No	❑ Yes	Who?
Clotting Disorders	❑ No	❑ Yes	Who?
Hemophilia	❑ No	❑ Yes	Who?
Sickle Cell	❑ No	❑ Yes	Who?
Thalassemia	❑ No	❑ Yes	Who?
Diabetes	❑ No	❑ Yes	Who?
Seizures	❑ No	❑ Yes	Who?
Mental Illness	❑ No	❑ Yes	Who?
Depression/Anxiety/Bipolar	❑ No	❑ Yes	Who?
Other	❑ No	❑ Yes	Who?
Cancer	❑ No	❑ Yes	Who?
Birth Defects	❑ No	❑ Yes	Who?
Hearing Loss	❑ No	❑ Yes	Who?
Speech Problems	❑ No	❑ Yes	Who?
Kidney Disease	❑ No	❑ Yes	Who?
Alcohol/Drug Abuse	❑ No	❑ Yes	Who?
Hepatitis/Liver Disease	❑ No	❑ Yes	Who?
Thyroid Disease	❑ No	❑ Yes	Who?
Learning Problems (Including ADD/ADHD)	❑ No	❑ Yes	Who?
Attention Deficit Disorder	❑ No	❑ Yes	Who?
Mental Retardation	❑ No	❑ Yes	Who?
Family Violence	❑ No	❑ Yes	Who?

Other Concerns:

Has any family member ever had an unexplained, unexpected death before age 50?
❑ No ❑ Yes (If yes, describe on back)

Reviewed by: Date:

continued>

Medical History Questionnaire

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PREGNANCY AND BIRTH HISTORY

Adopted ❑ No ❑ Yes

Prenatal care ❑ No ❑ Yes

Illnesses during pregnancy ❑ No ❑ Yes

Medications during pregnancy ❑ No ❑ Yes

Alcohol/drug abuse ❑ No ❑ Yes

Tobacco use ❑ No ❑ Yes

Problems at birth ❑ No ❑ Yes

Baby

- Jaundice ❑ No ❑ Yes
- Heart Murmur ❑ No ❑ Yes
- Infection ❑ No ❑ Yes
- Breathing Problems ❑ No ❑ Yes
- Birth Defects ❑ No ❑ Yes

Other:

Name of Hospital:

Full-Term Delivery: ❑ No ❑ Yes

Type of delivery: ❑ Vaginal ❑ C-section ❑ VBAC

Birth Weight:

Newborn Hearing Screen Passed? ❑ No ❑ Yes

Did baby receive Hep B vaccine ❑ No ❑ Yes

If Born Premature, how early?

FEEDING AND DIGESTION

Breast fed ❑ Formula ❑

Severe colic in first 3 months ❑ No ❑ Yes

Feeding problems ❑ No ❑ Yes

Takes vitamins ❑ No ❑ Yes

Constipation problems ❑ No ❑ Yes

Food allergies/issues ❑ No ❑ Yes

PSYCHOSOCIAL HISTORY

Who lives in household:

❑ Rent ❑ Own ❑ Shelter

Who cares for child:

Is child in daycare: ❑ No ❑ Yes

Type: ❑ Center

❑ Private home

Date of Birth:

Mother:

Father:

Parents divorced/separated: ❑ No ❑ Yes

Parents working:

Mother: ❑ No ❑ Yes

Father: ❑ No ❑ Yes

Parents use tobacco:

Mother: ❑ No ❑ Yes

Father: ❑ No ❑ Yes

Child use tobacco (12 years +) ❑ No ❑ Yes

Child Sleep Problems ❑ No ❑ Yes

Foster Care:

Dates: _____ _____

Other Languages:

MEDICAL HISTORY

Broken bones ❑ No ❑ Yes

Serious accidents ❑ No ❑ Yes

Operations ❑ No ❑ Yes

Hospitalizations ❑ No ❑ Yes

Explain:

Additional Information: