# 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:**

| Condition | No | Yes |
|---|---|---|
| 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:

| Condition | No | Yes | Who? |
|---|---|---|---|
| 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

<continued

## 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: