Medical History Questionnaire

Patient Name _____

Birth Date _____ Age _____ [ ] M [ ] F

Form Completed by _____ Date _____

The answers to the following questions will be helpful to your pediatrician in providing your child with the most comprehensive medical care. All information provided is kept confidential and will become part of your child's medical record. Thank you.

Tell Us about your Household – Please list all those living in child's home

Name	Relationship to	Date of Birth	Occupation

If parents are not living together or if child does not live with parents, what is the child's custody status?

_____

_____

Birth History

City/State/Country of Birth _____ Hospital _____

Full term pregnancy (37 weeks or more)? _____ If early, how many weeks? _____

Did the mother have any illness or complications during pregnancy? If yes, please explain. [ ]yes [ ]no

_____

Was the delivery [ ] vaginal? Or [ ] Caesarian? If Caesarian, why?

_____

Did your baby have any problems before leaving the hospital or in the first few weeks? [ ] yes [ ] no. If yes, please explain below.

_____

Birth Weight _____ APGARS _____ Hearing Screen at Birth? [ ] yes [ ] no

In the hospital, was the baby….

On Oxygen? [ ] yes [] no

On a ventilator? [ ] yes [] no

Hepatitis B vaccine at birth? [ ] yes [ ] no

If yes, date of vaccination _____

Under bilirubin lights(phototherapy?) [ ] yes [ ] no If yes, how many hours or days? _____

Child's Medical History

Growth and Development

At what age did your child (omit if too young)

Sit unsupported _____ months

Walk Alone _____months

Talk in 2 word sentences _____months

Has your child had any of the following?

Pneumonia [ ] Yes [ ] No

Heart Trouble [ ] Yes [ ] No

Kidney Disease [ ] Yes [ ] No

Seizures [ ] Yes [ ] No

Asthma [ ] Yes [ ] No

Eczema/sensitive skin [ ] Yes [ ] No

Chickenpox [ ] Yes [ ] No

Appendicitis [ ] Yes [ ] No

Whooping Cough [ ] Yes [ ] No

Anemia [ ] Yes [ ] No

Bladder Infection [ ] Yes [ ] No

Other serious illness [ ] Yes [ ] No

If yes, please explain:

_____

_____

_____

Has your child ever had (been)

Tonsil Adenoid surgery? [ ] Yes [ ] No

Broken bones? [ ] Yes [ ] No

Other serious injuries? [ ] Yes [ ] No

Head Injury requiring medical visit? [ ] Yes [ ] No

Treated for accidental poisoning? [ ] Yes [ ] No

Hospitalized for reasons other than those listed above?

_____

Please List any Medications your child takes on a regular basis

_____

Is your child allergic or intolerant of:

Medications [ ] Yes [ ] No

Foods [ ] Yes [ ] No

Other Items [ ] Yes [ ] No

If yes, please list: _____

_____

Has your child had:

Headaches more than twice a month? [ ] Yes [ ] No

Frequent bad stomach aches? [ ] Yes [ ] No

Frequent vomiting? [ ] Yes [ ] No

Fainting spells? [ ] Yes [ ] No

Trouble hearing? [ ] Yes [ ] No

Stuffy nose most of the time? [ ] Yes [ ] No

Shortness of breath with exercise? [ ] Yes [ ] No

Chronic Cough? [ ] Yes [ ] No

Asthma? [ ] Yes [ ] No

Heart Murmur or heart problem? [ ] Yes [ ] No

Frequent spells of diarrhea? [ ] Yes [ ] No

Constipation that requires visit? [ ] Yes [ ] No

Bladder or kidney infection? [ ] Yes [ ] No

Bedwetting after 10 years of age? [ ] Yes [ ] No

Seizures, other neurological problem? [ ] Yes [ ] No

Frequent nightmares? [ ] Yes [ ] No

Diabetes? [ ] Yes [ ] No

Thyroid or other hormone problem? [ ] Yes [ ] No

Recurrent skin problems (acne, eczema) [ ] Yes [ ] No

Any other significant problem? [ ] Yes [ ] No

If yes, please explain: _____

Family History

If any blood relatives have ever had any of these conditions, please check the appropriate box and indicate which family member. This should include maternal and paternal grandparents, aunts, uncles (please indicate with P for paternal or M for maternal) as well as immediate family.

Deafness	[ ] yes	[ ] no	Who_____	Comments _____
Nasal Allergies	[ ] yes	[ ] no	Who_____	Comments _____
Asthma	[ ] yes	[ ] no	Who_____	Comments _____
Tuberculosis	[ ] yes	[ ] no	Who_____	Comments _____
Heart Disease (before 50)	[ ] yes	[ ] no	Who_____	Comments _____
High Blood Pressure(before 50)	[ ] yes	[ ] no	Who_____	Comments _____
Celiac Disease	[ ] yes	[ ] no	Who_____	Comments _____
High Cholesterol	[ ] yes	[ ] no	Who_____	Comments _____
Anemia	[ ] yes	[ ] no	Who_____	Comments _____
Migraine Headaches	[ ] yes	[ ] no	Who_____	Comments _____
Bleeding Disorder	[ ] yes	[ ] no	Who_____	Comments _____
Thyroid Disease	[ ] yes	[ ] no	Who_____	Comments _____
Liver Disease	[ ] yes	[ ] no	Who_____	Comments _____
Kidney Disease	[ ] yes	[ ] no	Who_____	Comments _____
Cancers	[ ] yes	[ ] no	Who_____	Comments _____
Diabetes (before 50)	[ ] yes	[ ] no	Who_____	Comments _____
Bed-wetting (after 10)	[ ] yes	[ ] no	Who_____	Comments _____
Seizures or Seizure Disorder	[ ] yes	[ ] no	Who_____	Comments _____
ADD/ADHD	[ ] yes	[ ] no	Who_____	Comments _____
Alcohol Abuse	[ ] yes	[ ] no	Who_____	Comments _____
Drug Abuse	[ ] yes	[ ] no	Who_____	Comments _____
Mental Illness	[ ] yes	[ ] no	Who_____	Comments _____
Mental Retardation	[ ] yes	[ ] no	Who_____	Comments _____
Immune problems,HIV	[ ] yes	[ ] no	Who_____	Comments _____
Additional Family History	[ ] yes	[ ] no	Who_____	Comments _____

Please add any comments you feel are important regarding family history below.

_____

_____

Social History

On page 1 of the history form, you indicated the individuals related to your child. Please take a few moments to tell us about their home, daycare (when applicable), and school (when applicable) environment.

Home Environment:

Household 1:

Town in which home is located: _____

Type (apartment, house, trailer): _____

Year Built (approx. is ok): _____

Pets? If yes, type of pet: _____

Smoking? If yes, indicate indoors or out? _____

Weapons? Please indicate what type. _____

Potential Hazards (Lead, Radon, Mold) _____

Household 2 (when applicable):

Town in which home is located: _____

Type (apartment, house, trailer): _____

Year Built (approx. is ok): _____

Pets? If yes, type of pet: _____

Smoking? If yes, indicate indoors or out? _____

Weapons? Please indicate what type. _____

Potential Hazards (Lead , Radon, Mold) _____

_____

If your child is school age, please tell us which school your child attends and in what grade. _____

_____

What are your child's favorite activities in school? _____

_____

When not in school? _____

_____

Do you or your child's teacher(s) have any concerns about your child's behavior? If yes, what are the specific concerns?

_____

_____

If your child attends day care, please list day care providers and telephone number for that provider.

Provider Name: _____

Telephone Number: _____

Please use the space below to tell us anything that was not mentioned in this questionnaire and that you feel is relevant to your child's care here at Northeast Pediatrics and Adolescent Medicine.

_____