Medical/Family History Questionnaire

Practice Name: _____ Date of Entry: _____
Patient Name: _____ Date of Birth: _____
Address: _____ Phone No.: _____
_____ Emergency No.: _____
Source of Information: _____ Relationship: _____

Mother's Pregnancy/Child's Birth History: (under 2 yrs old)

Illness during Pregnancy? NO YES
Any medications during pregnancy? NO YES
Alcohol/Drug Abuse NO YES
Problems at Birth? NO YES
Describe: _____
Type of delivery? Vaginal C-Section
Birth Weight: _____ Discharge Weight: _____
Did baby receive hepatitis B vaccine? NO YES
Date of Hepatitis B vaccine: _____
Name of Hospital: _____
Was first PKU done? NO YES

Patient's Health History: Has your child ever had:

Measles/Mumps/Chicken Pox NO YES
Frequent Ear Infections NO YES
Vision/Hearing Problems NO YES
Skin Problems NO YES
Asthma/Allergies NO YES
TB/Lung Disease/Croup NO YES
Seizures/Epilepsy NO YES
High Blood Pressure NO YES
Heart defects/Disease NO YES
Liver Disease/Hepatitis NO YES
Diabetes NO YES
Kidney Disease/Bladder Infections NO YES
Handicaps/Disabilities NO YES
Bleeding Disorders/Hemophilia NO YES
Sexually Transmitted Diseases NO YES
Emotional problems/Suicide Attempts NO YES
Hospitalizations/Surgeries NO YES
Physical/Emotional Abuse/ Broken Bones NO YES
Immunizations Up-To-Date NO YES

Psycho-Social History:

How many living in the household? _____
Who cares for the child? _____
Are parents working: NO YES
Name of School: _____
Grade: _____
Behavioral problems:

Family History: Has anyone in the family (parents, grandparents, aunts, uncles, sister, brothers, cousins, etc.) had the following: Who:

TB/Lung Disease NO YES_____
HIV/AIDS NO YES_____
Suicide Attempts NO YES_____
Heart Disease NO YES_____
High Blood Pressure NO YES_____
High Cholesterol NO YES_____
Blood Disorders NO YES_____
Diabetes NO YES_____
Seizures NO YES_____
Allergies/Asthma NO YES_____
Developmental Delays NO YES_____
Mental Illness NO YES_____
Cancer NO YES_____
Birth Defects NO YES_____
Hearing/Speech Problems NO YES_____
Kidney Disease NO YES_____
Alcohol/Drug Abuse NO YES_____
Stroke NO YES_____
Hepatitis/Liver Disease NO YES_____
Thyroid Disease NO YES_____
Learning Problems NO YES_____
Attention Deficit NO YES_____
Disorder NO YES_____
Family Violence NO YES

Adolescent History: (Interview Separately)

Age at first period_____ LMP_____
Sexually Active NO YES # of partners _____
Sex of Partners MALE FEMALE
Any fear of partner/other violence? NO YES
Smoker: NO YES Alcohol Use: NO YES
Drug Use: NO YES Working: NO YES
Do you think about hurting yourself? NO YES
Access to gun/weapons: NO YES

_____
_____
Comments:_____
_____
Updates:_____/_____/_____/_____/_____/_____/_____/_____/_____

Provider Signature: _____ Date:_____