MEDICAL HISTORY
QUESTIONNAIRE (page 1 of 2)

Name _____
Birth Date _____ Age _____ ☐ M ☐ F
Form Completed by _____ Date Completed _____

BIRTH HISTORY

Birth weight _____
Born at which Hospital? _____
Was the baby born at term? ☐ Yes ☐ No
Explain _____
Did the mother have any problems with pregnancy? ☐Y ☐N
Explain _____
During pregnancy, did mother smoke? ☐ Yes ☐ No
Drink alcohol ☐ Yes ☐ No Use drugs or medications ☐ Y ☐N
Explain _____

Was delivery ☐ Vaginal? ☐ Cesarean?
If cesarean, why? _____
Did your baby have an problems right after birth?
☐ Yes ☐ No Explain _____
Did your baby go home with the mother from the hospital?
☐ Yes ☐ No Explain _____
Did your baby pass the hearing screen? ☐ Yes ☐ No

MEDICAL HISTORY

Medical Problems

_____ _____
_____ _____
_____ _____
_____ _____

Past Hospitalizations (date and reason)

_____
_____
_____
_____

Past surgeries (date and reason)

_____
_____
_____
_____

Medication names & dosages

_____
_____
_____
_____

Allergies (please list)

_____
_____
_____
_____

DEVELOPMENT

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain _____
Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No Explain _____
Are you concerned about your child's attention span? ☐ Yes ☐ No Explain _____
Are you concerned about your child's speech? ☐ Yes ☐ No Explain _____
Are you concerned about your child's behavior at home or in school? ☐ Yes ☐ No Explain _____
Are you concerned about your child's sleeping habits? ☐ Yes ☐ No Explain _____
Are you concerned about your child's progress in school? ☐ Yes ☐ No Explain _____
Does your child participate in any extracurricular activities? ☐ Yes ☐ No Explain _____

MEDICAL HISTORY
QUESTIONNAIRE (page 2 of 2)

SONRISE Pediatrics & Wellness

FAMILY HISTORY

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 yrs. old)	☐ Yes	☐ No	Who _____	Comments _____
High Blood pressure (before 50)	☐ Yes	☐ No	Who _____	Comments _____
Unexplained death (before 50)	☐ Yes	☐ No	Who _____	Comments _____
High cholesterol	☐ Yes	☐ No	Who _____	Comments _____
Anemia	☐ Yes	☐ No	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	Who _____	Comments _____
Liver disease	☐ Yes	☐ No	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	Who _____	Comments _____
Diabetes (before 50 yrs. old)	☐ Yes	☐ No	Who _____	Comments _____
Bed-wetting (after 10 yrs. Old)	☐ Yes	☐ No	Who _____	Comments _____
Epilepsy or seizures	☐ Yes	☐ No	Who _____	Comments _____
Alcohol/drug abuse	☐ Yes	☐ No	Who _____	Comments _____
Mental illness	☐ Yes	☐ No	Who _____	Comments _____
Immune problems, HIV or AIDS	☐ Yes	☐ No	Who _____	Comments _____
Additional family History	☐ Yes	☐ No	Who _____	Comments _____

PAST HISTORY

Does your child have or has he/she ever had:

Frequent ear infections	☐ Yes	☐ No	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	Explain _____
Nasal allergies	☐ Yes	☐ No	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	Explain _____
Asthma, bronchitis, pneumonia or chronic cough	☐ Yes	☐ No	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	Explain _____
Blood transfusion	☐ Yes	☐ No	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	Explain _____
Bladder or kidney infection (UTI)	☐ Yes	☐ No	Explain _____
Bed-wetting (after 5-years old)	☐ Yes	☐ No	Explain _____
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain _____
Any chronic/recurrent skin problem (acne/eczema)	☐ Yes	☐ No	Explain _____
Frequent headaches	☐ Yes	☐ No	Explain _____
Seizures or other neurologic problems	☐ Yes	☐ No	Explain _____
Diabetes	☐ Yes	☐ No	Explain _____
Thyroid or other endocrine problem	☐ Yes	☐ No	Explain _____
Any other significant problem	☐ Yes	☐ No	Explain _____
Use of alcohol, drugs, tobacco or vaping	☐ Yes	☐ No	Explain _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform SonRise Pediatrics or any changes in my child's medical status.

_____

Signature of Parent or Guardian