# MEDICAL HISTORY QUESTIONNAIRE

# Tomahawk Farm Pediatrics PC

Name_____

Birth Date _____ Age _____ ❑ M ❑ F

Form Completed by_____ Date Completed _____

## HOUSEHOLD

Please list all those living in child's home.

| Name | Relationship to | Date of Birth | Health Problems |
|---|---|---|---|
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## BIRTH HISTORY

Birth weight_____

Born at which hospital? _____
Was the baby born at term?_____Early?_____ Late?_____

Did the mother have any or illness with her pregnancy? ❑ Yes ❑ No
Explain_____

During the pregnancy, did mother smoke ❑ Yes ❑ No

Drink alcohol ❑ Yes ❑ No Use drugs or medications ❑ Yes ❑ No

What?_____When?_____

Was the delivery ❑ Vaginal? ❑ Cesarean?
If cesarean, why?_____

Did your baby have any problems right after birth?

❑ Yes ❑ No Explain_____

Did your baby go home with the mother from the hospital?

❑ Yes ❑ No Explain_____

## GENERAL

Do you consider your child to be in good health? ❑ Yes ❑ No Explain_____

Does your child have any serious illness or medical condition? ❑ Yes ❑ No Explain_____

Has your child had serious injuries or accidents? ❑ Yes ❑ No Explain_____

Has your child had any surgery? ❑ Yes ❑ No Explain_____

Is your child allergic to any medicines or drugs? ❑ Yes ❑ No Explain_____

Any admissions to a hospital? ❑ Yes ❑ No Explain_____

## 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_____

If your child is in school:

How is his/her behavior in school?_____

Has he/she failed or repeated a grade in school?_____

How is he/she doing in academic subjects?_____

Is he/she in special or resource classes?_____

## 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 years old) | ❑ Yes | ❑ No | Who_____ | Comments _____ |
| High blood pressure (before 50 years old) | ❑ 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 years old) | ❑ Yes | ❑ No | Who_____ | Comments _____ |
| Bed-wetting (after 10 years old) | ❑ Yes | ❑ No | Who_____ | Comments _____ |
| Epilepsy or convulsions | ❑ 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, 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:

| | | | |
|---|---|---|---|
| Chickenpox | ❑ Yes | ❑ No | When_____ |
| 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, bronchiolitis, or pneumonia | ❑ 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 | ❑ Yes | ❑ No | Explain_____ |
| Bed-wetting (after 5-years old) | ❑ Yes | ❑ No | Explain_____ |
| (For girls) Has she started he menstrual periods? | ❑ Yes | ❑ No | Explain_____ |
| (For girls) Are there problems with her periods? | ❑ Yes | ❑ No | Explain_____ |
| Any chronic or recurrent skin problem (acne, eczema, etc.) | ❑ Yes | ❑ No | Explain_____ |
| Frequent headaches | ❑ Yes | ❑ No | Explain_____ |
| Convulsions or other neurologic problem | ❑ 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 or drugs | ❑ 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 Tomahawk Farm Pediatrics of any changes in my child's medical status.

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Signature of Parent or Guardian