

## Patient Medical History Questionnaire

Date of Birth \_\_\_\_\_ Form completed by \_\_\_\_\_ Date of completion \_\_\_\_\_

### HOUSEHOLD Please list all those living in the child's home:

Name	Relationship to child	Date of birth	Heath problems

### BIRTH HISTORY

Birth weight: \_\_\_\_\_ Baby born at term? \_\_\_\_\_ Early? \_\_\_\_\_ Late? \_\_\_\_\_

If early, how many weeks gestation? \_\_\_\_\_

Did mother have any illness or problems with her pregnancy? \_\_\_\_\_

During pregnancy did mother  drink alcohol?  smoke?  use any drugs or medications?

If so what, when, how much? \_\_\_\_\_

Was delivery  Vaginal?  Cesarean?

If Cesarean, why? \_\_\_\_\_ Did baby have any problems right after birth?  Yes  No

If yes, explain \_\_\_\_\_

Was initial feeding  breast?  bottle?

Did your baby go home with you from the hospital?  yes  no If no, explain. \_\_\_\_\_

### GENERAL

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 \_\_\_\_\_

Has your child ever been hospitalized?  yes  no Explain \_\_\_\_\_

Is your child allergic to medications?  yes  no Explain \_\_\_\_\_

Is your child currently on any medications?  yes  no Explain \_\_\_\_\_

Do you have any feeding or nutritional concerns?  yes  no Explain \_\_\_\_\_

Has your child had any growth problems?  yes  no Explain \_\_\_\_\_

Has your child received any immunizations?  yes  no

**Please bring a copy of your child's immunization record.**

### DEVELOPMENT

Are you concerned about your child's physical development?  yes  no Explain \_\_\_\_\_

Are you concerned about your child's mental/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 academically? \_\_\_\_\_

Is he/she in any special or resource classes? \_\_\_\_\_

**PAST MEDICAL HISTORY****Does your child have, or has he/she ever had:**

- Chickenpox?  yes  no Explain \_\_\_\_\_
- Frequent ear infections?  yes  no Explain \_\_\_\_\_
- Problem with ears or hearing?  yes  no Explain \_\_\_\_\_
- Nasal allergies?  yes  no Explain \_\_\_\_\_
- Problems with eyes or vision?  yes  no Explain \_\_\_\_\_
- Frequent strep throat or snoring?  yes  no Explain \_\_\_\_\_
- Asthma, bronchitis, bronchiolitis, or pneumonia?  yes  no Explain \_\_\_\_\_
- Any heart problems 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's visits?  yes  no Explain \_\_\_\_\_
- Bladder or kidney infection?  yes  no Explain \_\_\_\_\_
- Bedwetting after 5 years of age?  yes  no Explain \_\_\_\_\_
- (For girls) Has she started her menstrual periods?  yes  no Explain \_\_\_\_\_
- (For girls) Any problems with her periods?  yes  no Explain \_\_\_\_\_
- Any chronic skin problems? (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, drugs, or tobacco?  yes  no Explain \_\_\_\_\_