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: _____
Behavior problems: _____
_____
Comments: _____
_____
Updates: _____/_____/_____/_____/_____/_____/_____

Family History: Has anyone in the family (parents, grandparents, aunts & uncles, sisters & 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	_____
Mental Retardation	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 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 fears 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/weapon:	NO	YES

Provider Signature: _____ **Date:** _____