



MEDICAL HISTORY QUESTIONNAIRE

Doctors' Pediatric, P.C.

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

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home?

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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Nasal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Heart disease (before 50 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
High blood pressure (before 50 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
High cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Diabetes (before 50 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Bed-wetting (after 10 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Epilepsy or convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Alcohol abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Drug abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Mental illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Mental retardation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Immune problems, HIV, or AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Additional family history	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____

PAST HISTORY

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

Chickenpox	<input type="checkbox"/> Yes <input type="checkbox"/> No	When _____
Frequent ear infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Problems with ears or hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Nasal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Problems with eyes or vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Any heart problem or heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Anemia or bleeding problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Blood transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Frequent abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Constipation requiring doctor visits	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Bladder or kidney infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Bed-wetting (after 5-years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
(For girls) Has she started her menstrual periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
(For girls) Are there problems with her periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Any chronic or recurrent skin problem (acne, eczema, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Frequent headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Convulsions or other neurologic problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Thyroid or other endocrine problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Any other significant problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
Use of alcohol or drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____