Medical / Family History Questionnaire

Patient Name :(last)	(first)	Chart #
Patient date of birth:	Patient sex (check) ☐ male ☐ female	Today's date:
Form completed by:	Relationship:	

Pregnancy and Birth History	Psychosocial History
Name of Hospital	Who lives in household?
Illnesses during pregnancy? no ☐ yes ☐	
Medications during pregnancy? no ☐ yes ☐	Total persons in household?
Alcohol/drug abuse? no ☐ yes ☐	☐ own ☐ rent ☐ shelter
Problems at birth? no ☐ yes ☐	Who cares for child?
Describe:	Mother date of birth:
Type of delivery vaginal ☐ C-section ☐	Father date of birth:
Birth Weight: Discharge weight:	Are parents working? mother ☐ yes ☐ no
Did baby receive Hepatitis B vaccine? no ☐ yes ☐	father ☐ yes ☐ no
Date of Hepatitis B vaccine:	Foster care? ☐ yes ☐ no Dates:
Newborn hearing screen? no ☐ yes ☐	Other languages:
	Check if in home: ☐ gun ☐ pets ☐ smoking
	Water: ☐ city ☐ well

Family History	Medical History
Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:	Has your child ever had:
Who?	
Allergies (list) no ☐ yes ☐	Allergies (list) no ☐ yes ☐
Asthma no ☐ yes ☐	Asthma no ☐ yes ☐
TB / Lung disease no ☐ yes ☐	Chicken pox (year) no ☐ yes ☐
HIV/Aids no ☐ yes ☐	Frequent ear infections no ☐ yes ☐
Suicide Attempts no ☐ yes ☐	Vision / Hearing problems no ☐ yes ☐
Heart Disease no ☐ yes ☐	Skin problems/ Eczema no ☐ yes ☐
High Blood Pressure/Stroke no ☐ yes ☐	TB / Lung Disease no ☐ yes ☐
High cholesterol no ☐ yes ☐	Seizures / Epilepsy no ☐ yes ☐
Blood Disorders / Sickle Cell no ☐ yes ☐	High Blood Pressure no ☐ yes ☐
Diabetes no ☐ yes ☐	Heart Defects / Disease no ☐ yes ☐
Seizures no ☐ yes ☐	Liver Disease / Hepatitis no ☐ yes ☐
Mental Illness no ☐ yes ☐	Diabetes no ☐ yes ☐
Cancer no ☐ yes ☐	Kidney disease / Bladder Infections no ☐ yes ☐
Birth Defects no ☐ yes ☐	Physical or Learning Disabilities no ☐ yes ☐
Hearing Loss no ☐ yes ☐	Bleeding disorders / Hemophilia no ☐ yes ☐
Speech Problems no ☐ yes ☐	Sexually Transmitted Diseases no ☐ yes ☐
Kidney Disease no ☐ yes ☐	Emotional or Behavioral problems no ☐ yes ☐
Alcohol/Drug Abuse no ☐ yes ☐	Depression / Suicidal thoughts no ☐ yes ☐
Hepatitis/Liver no ☐ yes ☐	Hospitalizations / surgeries no ☐ yes ☐
Thyroid Disease no ☐ yes ☐	Physical / emotional / sexual abuse no ☐ yes ☐
Learning Problems/ Attention Deficit Disorder no ☐ yes ☐	Bone or Joint injuries no ☐ yes ☐
Family Violence no ☐ yes ☐	Obesity / Eating disorders no ☐ yes ☐
Sudden Death no ☐ yes ☐	Other:
Other:	Current Medication(s) list:

Updates: