

# Sewanee Pediatric and Adolescent Medicine

## MEDICAL/FAMILY HISTORY QUESTIONNAIRE

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

Source of Information \_\_\_\_\_ Relationship \_\_\_\_\_ Immunizations (please provide a copy of record)

<b>Mother's Pregnancy /Child's Birth History:(under 6 years old)</b>	
Problems during pregnancy?	
Medications during pregnancy?	
Tobacco/ Alcohol/ Drug use?	
Problems at birth?	
Prematurity?	
Type of delivery?	
Birth Weight?	Discharge Weight?
Did baby pass hearing screen?	
Date of Hepatitis B immunization	
Formula fed?	
Breast fed?	
<b>Patient's Health History; Has your child ever had...</b>	
Chicken Pox?	
Vision/ Hearing Problems?	
Frequent ear infections?	
Allergies?	
Dental Decay?	
High Blood Pressure?	
Heart Defects/ Disease?	
Asthma?	
Liver Disease/ Hepatitis?	
Kidney Disease/ Bladder Infections?	
Skin Problems?	
Seizures/ Epilepsy?	
Broken Bones? Serious Injuries?	
Diabetes?	
Thyroid Disease?	
Anemia?	
Bleeding Disorders? Hemophilia?	
Obesity/ Overweight?	
Development Delays?	
Behavioral Problems?	
Emotional Problems?	
Sleep Concerns?	
ADHD?	
Physical/Emotional Abuse?	
School Problems?	
Sexually Transmitted Diseases?	
Exposure to Smoking?	

<i>Significant Health Problems:</i>		
<i>Hospitalizations:</i>		
<i>Surgeries:</i>		
<i>Current Medications and Dosage:</i>		
<i>Allergies:</i>		
Medications: _____		
Foods: _____		
Environmental: _____		
<b>Family History:</b> Have any family members (parents, grandparents aunts/uncles, sisters/brothers) had the following:		
Condition	Relationship to Child	Select Y or N
Childhood hearing loss?		
Birth Defects?		
Heart Disease?		
High Blood Pressure?		
High Cholesterol?		
Sudden death?		
Asthma?		
Allergies?		
TB/Lung Disease?		
Liver Disease?		
Kidney Disease?		
Seizures?		
Thyroid Disease?		
Diabetes?		
Cancer?		
HIV/AIDS?		
Bleeding Disorder?		
Obesity?		
Anemia?		
Learning Problems?		
ADHD?		
Mental Illness?		
Alcohol/Drug Abuse?		

<b>HOUSEHOLD MEMBERS</b> (please list all those living in child's home)			
Name	Relationship to Child	Date of Birth	Health Problems
What is the child's living situation if not with both biological parents? (check one) Single Custody                      Joint Custody                      Adoptive Parents                      Foster Family If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?			