Medical/Family History Questionnaire

MEDICAL HISTORY

Does your child have allergies to foods or medications? No ☐ Yes ☐

If yes, please specify: _____

Has your child had any surgeries? No ☐ Yes ☐

If yes, please specify: _____

Has your child ever been hospitalized? No ☐ Yes ☐

If yes, please specify: _____

Has your child had any serious injuries? No ☐ Yes ☐

If yes, please specify: _____

Has your child had a severe reaction to an insect bite? (e.g. shortness of breath, tongue swelling) No ☐ Yes ☐

If yes, please specify: _____

Any reactions to immunizations? No ☐ Yes ☐

If yes, please specify: _____

Are your child's immunizations up to date? No ☐ Yes ☐

Do you have an immunization record? No ☐ Yes ☐

Has your child ever had:

Asthma	No ☐	Yes ☐
Chicken Pox (Year) _____	No ☐	Yes ☐
Frequent Ear Infections	No ☐	Yes ☐
Vision/Hearing Problems	No ☐	Yes ☐
Skin Problems/Eczema	No ☐	Yes ☐
TB/Lung Disease	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 ☐
Physical or Learning Disabilities	No ☐	Yes ☐
Bleeding Disorders/Hemophilia	No ☐	Yes ☐
Sexually Transmitted Diseases	No ☐	Yes ☐
Emotional or Behavioral Problems	No ☐	Yes ☐
Depression/Suicidal Thoughts	No ☐	Yes ☐
Physical/Emotional/Sexual Abuse	No ☐	Yes ☐
Bone or Joint Injuries	No ☐	Yes ☐
Obesity/Eating Disorders	No ☐	Yes ☐
Has your child had pneumonia?	No ☐	Yes ☐
Does your child have a frequent cough?	No ☐	Yes ☐
Do you own an aerosol machine?	No ☐	Yes ☐
Problems with diarrhea or constipation?	No ☐	Yes ☐

If yes, please explain: _____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

			Who?
Asthma	No ☐	Yes ☐	
TB/Lung Disease	No ☐	Yes ☐	
HIV/AIDS	No ☐	Yes ☐	
Suicide Attempts	No ☐	Yes ☐	
Heart Disease	No ☐	Yes ☐	
High Blood Pressure/Stroke	No ☐	Yes ☐	
High Cholesterol	No ☐	Yes ☐	
Blood Disorders/Sickle Cell	No ☐	Yes ☐	
Diabetes	No ☐	Yes ☐	
Seizures	No ☐	Yes ☐	
Cancer	No ☐	Yes ☐	
Birth Defects	No ☐	Yes ☐	
Hearing Loss	No ☐	Yes ☐	
Speech Problems	No ☐	Yes ☐	
Kidney Disease	No ☐	Yes ☐	
Alcohol/Drug Abuse	No ☐	Yes ☐	
Hepatitis/Liver Disease	No ☐	Yes ☐	
Thyroid Disease	No ☐	Yes ☐	
Learning Problems/Attention	No ☐	Yes ☐	
Family Violence	No ☐	Yes ☐	
Mental Illness	No ☐	Yes ☐	

Allergies (please specify whom/what?) _____

WESTCHESTER PEDIATRICS LLC

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Medical/Family History Questionnaire

Patient Name:	Date of Birth:	Sex: (circle) Male Female
Form Completed By: / Today's Date	Relationship:	

Mother's Name: _____
Occupation: _____
Mother's Health: _____
Marital Status: _____

Father's Name: _____
Occupation: _____
Father's Health: _____
Marital Status: _____

Do the child's parents live together? No ☐ Yes ☐
Does the patient have any siblings? No ☐ Yes ☐

If so, please give siblings' names, ages, and health status:

_____

_____

Whom does the child live with? _____

_____

_____

Have any of your children died? No ☐ Yes ☐

Housing status?
☐ **Renting** ☐ **Owns a House** ☐ **Living with relatives**

☐ **Shelter** ☐ **Homeless**

Who cares for the child while you are at work? _____

_____

Is the patient in Foster care? No ☐ Yes ☐

What languages are used at home? _____

_____

Any assistive communication devices needed? (for vision, hearing, and/or cognitive issues) No ☐ Yes ☐

If yes, please specify: _____

_____

PREGNANCY AND BIRTH HISTORY

Mother's age at time of birth: _____
Name of Hospital: _____
Gestational Age: _____
Illnesses during pregnancy? No ☐ Yes ☐
Medications during pregnancy? No ☐ Yes ☐
Alcohol/Drug Abuse? No ☐ Yes ☐
Problems at birth? No ☐ Yes ☐
If yes, what kind? _____

_____

Type of delivery? ☐ **Vaginal** ☐ **C-Section**
Baby's birth weight _____

Feeding and Nutrition

Was this child breast fed or formula fed? _____
If still on formula, which one? _____
Does your child take vitamins? No ☐ Yes ☐
Were there any unusual feeding issues in the first 6 months of life? No ☐ Yes ☐
Does your child have any food allergies? No ☐ Yes ☐
If yes, what kinds? _____

_____

Development and Behavior

Does your child enjoy playing with others? No ☐ Yes ☐
Does your child have any problems with bed wetting or speech? No ☐ Yes ☐
At what age did your child walk alone? _____
What school does your child attend? _____

Safety and Environment

Do you know the hottest temperature of the water in your pipes? No ☐ Yes ☐
Is there a working smoke alarm on each floor of the house? No ☐ Yes ☐
Does your child always use a car seat or seat belt when riding a car? No ☐ Yes ☐
Are there any smokers in the house? No ☐ Yes ☐
Are there any problems with the condition of your house? (peeling paint, rats, or mice) No ☐ Yes ☐
Does your child always wear a helmet when riding a bicycle? No ☐ Yes ☐
Does your child know how to swim? No ☐ Yes ☐