Medical History Questionnaire - New Patients (3 years & older)

Patient Name:	Gender: M F	Birthdate:

HOUSEHOLD - *Please list everyone living in the child's home.*

Name	Relationship to Child	Birthdate	Health Problems

If parents do not live together, or if child does not live with parents, what is the child's custody status?

_____

Does anyone in the home use tobacco? Yes No Are there any pets in the home? Yes No

GENERAL

Do you consider your child to be in good health?	Yes	No	Explain_____
Does your child have a serious illness or medical condition?	Yes	No	Explain_____
Has he/she had serious injuries or accidents?	Yes	No	Explain_____
Has your child had surgery of any kind?	Yes	No	Explain_____
Has your child ever been hospitalized?	Yes	No	Explain_____
Is your child allergic to any medicines or drugs?	Yes	No	Explain_____

DEVELOPMENT

Are you concerned about your child's physical, emotional, or social development?	Yes	No	Explain_____

YOUR CHILD'S PAST HISTORY -- *Does your child have, or has he/she ever had:*

Chickenpox?	Yes	No	When? _____	Ongoing or Resolved?
Frequent ear infections?	Yes	No	When? _____	Ongoing or Resolved?
Problems with ears or hearing?	Yes	No	When? _____	Ongoing or Resolved?
Nasal/seasonal allergies?	Yes	No	When? _____	Ongoing or Resolved?
Problems with eyes or vision?	Yes	No	When? _____	Ongoing or Resolved?
Asthma, bronchitis, bronchiolitis, or pneumonia?	Yes	No	When? _____	Ongoing or Resolved?
Any heart problems or murmur?	Yes	No	When? _____	Ongoing or Resolved?
Anemia or bleeding problems?	Yes	No	When? _____	Ongoing or Resolved?
Blood transfusion?	Yes	No	When? _____	Ongoing or Resolved?
Frequent abdominal pain?	Yes	No	When? _____	Ongoing or Resolved?
Constipation requiring doctor visit?	Yes	No	When? _____	Ongoing or Resolved?
Bladder or kidney infection?	Yes	No	When? _____	Ongoing or Resolved?
Bed-wetting (after age 5yr)?	Yes	No	When? _____	Ongoing or Resolved?
Girls: Has she started her menstrual period?	Yes	No	When? _____	Ongoing or Resolved?
Girls: Are there any problems with periods?	Yes	No	When? _____	Ongoing or Resolved?
Any chronic or recurrent skin problems?	Yes	No	When? _____	Ongoing or Resolved?
(Acne, Eczema, etc.)	Yes	No	When? _____	Ongoing or Resolved?
Frequent headaches?	Yes	No	When? _____	Ongoing or Resolved?
Convulsions or other neurological problem?	Yes	No	When? _____	Ongoing or Resolved?
Diabetes?	Yes	No	When? _____	Ongoing or Resolved?
Thyroid or other endocrine problem?	Yes	No	When? _____	Ongoing or Resolved?
Any other significant problem?	Yes	No	When? _____	Ongoing or Resolved?
Use of alcohol and abuse?	Yes	No	When? _____	Ongoing or Resolved?

please complete questions on back also*

FAMILY HISTORY -- *Has any parent, grandparent, or sibling had the following:*

Deafness? Yes No Who?_____ Alcohol abuse? Yes No Who? _____

Seasonal Allergies?	Yes	No	Who?_____
Asthma?	Yes	No	Who?_____
Tuberculosis?	Yes	No	Who?_____
Heart disease (before age 50yr)?	Yes	No	Who?_____
High blood pressure?	Yes	No	Who?_____
High cholesterol?	Yes	No	Who?_____
Anemia?	Yes	No	Who?_____
Bleeding Disorder?	Yes	No	Who?_____
Liver Disease?	Yes	No	Who?_____
Kidney Disease?	Yes	No	Who?_____
Diabetes (before age 50)?	Yes	No	Who?_____
Seizures?	Yes	No	Who?_____
Bed-wetting (after age 10)?	Yes	No	Who?_____
Mental illness or retardation?	Yes	No	Who?_____

Immune problems, HIV or AIDS?
Yes No Who? _____

Additional family history?

_____

_____

_____

Form Completed by: _____ Date: _____

(Signature)