Medical History Questionnaire - Newborn through 2 years of age

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

BIRTH HISTORY -- *Skip to next section if our providers cared for your baby while in the newborn nursery*

Birth Weight _____

Was the baby born at term: Yes No Early Late

If early, how many week's gestation? _____

Did mother have any illness/problems with pregnancy?
Yes No Explain, if yes_____

During pregnancy, did mother:
Smoke? Yes No Drink Alcohol? Yes No

Use drugs or medications? Yes No

If so, what and when? _____

Was delivery : Vaginal Cesarean

If Cesarean, why? _____

Did your baby have any issues right after birth?
Yes No Explain, if yes_____

Was initial feeding: Breast Bottle

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_____

Do you consider that your child has had normal social, emotional, and physical development? Yes No

If no, explain_____

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

Deafness? 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?_____

Alcohol abuse? Yes No Who? _____

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

Additional family history?

_____

_____

_____

Form Completed by: _____
(Signature)

Date: _____