MEDICAL/FAMILY HISTORY QUESTIONNAIRE

Practice Name: Bay Shore Pediatrics

Today's Date: _____

Patients Name: _____

Date of Birth: _____

Address: _____

Home Ph#: _____

City: _____State: _____Zip: _____

Emergency Ph#: _____

Person filling out form: _____

Relationship to patient: _____

Mother's Pregnancy/Child's Birth History: (under 2 yrs old)

Illnesses during pregnancy?	No	Yes
Any medications during pregnancy?	No	Yes
Alcohol/Drug Abuse?	No	Yes
Problems at Birth?	No	Yes

Describe: _____

Type of Delivery? Vaginal C-Section

Birth Weight: _____ Discharge Weight: _____

Did Baby receive Hepatitis B Vaccine?	No	Yes

Date of Hepatitis B immunization: _____

Name of Hospital: _____

Was First PKU Done?	No	Yes

Patients Health History: Has your child ever had:

Measles/Mumps/Chicken Pox?	No	Yes
Frequent ear infections?	No	Yes
Vision/Hearing Problems?	No	Yes
Skin Problems?	No	Yes
Asthma/Allergies?	No	Yes
TB/Lung Disease/Croup?	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
Handicaps/Disabilities?	No	Yes
Bleeding Disorders/Hemophilia?	No	Yes
Sexually Transmitted Diseases?	No	Yes
Emotional Problems?Suicide Attempts?	No	Yes
Hospitalizations/Surgeries?	No	Yes
Physical/Emotional Abuse/Broken Bones?	No	Yes
Immunizations Up-to-date?	No	Yes

Psycho-Social History

How many living in the household? _____

Who care for child? _____

Are parents working?	No	Yes

Name of school? _____

Grade: _____

Behavior problems? _____

Family History: Has anyone in the family (parents, grand parents Aunts/Uncles, Sister/Brothers, Cousins, etc.) Had the following:

TB/Lung Disease?	No	Yes	Who: ___
HIV/AIDS?	No	Yes	Who: ___
Suicide Attempts?	No	Yes	Who: ___
Heart Disease?	No	Yes	Who: ___
High Blood Pressure?	No	Yes	Who: ___
High Cholesterol?	No	Yes	Who: ___
Blood Disorders?	No	Yes	Who: ___
Diabetes?	No	Yes	Who: ___
Seizures?	No	Yes	Who: ___
Allergies/Asthma?	No	Yes	Who: ___
Mental Illness?	No	Yes	Who: ___
Mental Retardation?	No	Yes	Who: ___
Cancer?	No	Yes	Who: ___
Birth Defects?	No	Yes	Who: ___
Hearing/Speech Problems	No	Yes	Who: ___
Kidney Disease?	No	Yes	Who: ___
Alcohol/Drug Abuse	No	Yes	Who: ___
Stroke?	No	Yes	Who: ___
Hepatitis/Liver Disease?	No	Yes	Who: ___
Thyroid Disease?	No	Yes	Who: ___
Learning Problems?	No	Yes	Who: ___
Attention Deficit Disorder?	No	Yes	Who: ___

Adolescents History of child: (interview separately)

Age @ first Period _____ LMP _____

Sexually Active? No Yes # of partners? _____

Sex of partners? M/F

Any fears of partner/other violence?				No	Yes
Smoker?	No	Yes	Alcohol Use?	No	Yes
Drug Use?	No	Yes	Working?	No	Yes
Do you think about hurting yourself?				No	Yes
Access to gun/weapon?				No	Yes

Provider: _____

Date: _____

Comments:

_____

_____

__

Updates: _____/_____/_____/_____/_____/_____/_____/_____/_____/_____