PEDIATRIC MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

Other Concerns: _____

DEMOGRAPHICS: (Please check one for each category)

Race: □ American Indian □ Asian □ Black of African American

□ Native Hawaiian or other Pacific Islander □ White □ Refuse

Ethnicity: □ Non-Hispanic □ Hispanic □ Refuse

ALLERGIES:

Please list anything you are allergic to (medications, food, bee stings, etc.) and how each affects you:

Allergy:	Reaction
1. _____	_____
2. _____	_____
3. _____	_____

FAVORITE PHARMACY: _____

MEDICATIONS:

Please list all medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins/inhalers.

Drug Name:	Strength:	Frequency Taken:
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		
10. _____		

IMMUNIZATION HISTORY:

Immunizations and most recent date:

- ☐ Chickenpox Date: _____
- ☐ Flu Shot Date: _____
- ☐ Gardasil/HPV Date: _____
- ☐ Hepatitis A Date: _____
- ☐ Hepatitis B Date: _____
- ☐ Meningococcus Date: _____
- ☐ MMR (Measles, Mumps, Rubella) Date: _____
- ☐ Pneumonia (Pneumovax) Date: _____
- ☐ Tdap (Tetanus and Pertussis) Date: _____
- ☐ Tetanus Date: _____
- ☐ Zostavax (Shingles) Date: _____

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY:

Last PAP Smear Date: _____ ☐ Abnormal

Last Mammogram Date: _____ ☐ Abnormal

Age of first menstrual period: _____

Date of last menstrual period or age of menopause: _____

Number of pregnancies: _____ Births: _____

Miscarriages: _____ Abortions: _____

☐ Cesarean Sections If yes, then number of: _____

- ☐ Bleeding between periods
- ☐ Heavy periods
- ☐ Extreme menstrual pain
- ☐ Vaginal itching, burning, or discharge
- ☐ Wake in the night to go to the bathroom
- ☐ Hot flashes
- ☐ Breast Lump or nipple discharge
- ☐ Painful intercourse
- ☐ Sexually active
  Current sexual partner is ☐ M ☐ F
  Do you use condoms? ☐ Yes ☐ No
  Other birth control method: _____
  ☐ Interested in being screened for STD's

PAST MEDICAL HISTORY:

Please check all that apply:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Appendicitis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ Cancer
  - Type: _____
- ☐ Coronary Artery Disease
- ☐ Diabetes – Insulin
- ☐ Diabetes – Non-Insulin
- ☐ Dialysis
- ☐ Diverticulosis/Diverticulitis
- ☐ Fibromyalgia
- ☐ Gallstones
- ☐ Gout
- ☐ Heart Attack
- ☐ Heartburn
- ☐ Heart Murmur
- ☐ Hiatal Hernia
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg-Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Peptic Ulcer Disease
- ☐ Pulmonary Embolism
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Other: _____
  _____

PAST SURGICAL HISTORY:

Surgery:	Year:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

FAMILY HEALTH HISTORY:

If any of the following family members have been diagnosed with Cancer (if so, what type), Diabetes, Heart Disease, Hypertension, or any other major disease/illness, please fill in the following:

Family Member:	Alive Y/N:	Age:	Disease(s)/Illness:
Mother	_____	_____	_____
Father	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____
Sibling (Circle): Brother / Sister	_____	_____	_____
Sibling (Circle): Brother / Sister	_____	_____	_____
Sibling (Circle): Brother / Sister	_____	_____	_____
Sibling (Circle): Brother / Sister	_____	_____	_____
Sibling (Circle): Brother / Sister	_____	_____	_____

PRENATAL HISTORY

Problems: (Check all that apply)

- ☐ Multiple Gestation
- ☐ Infections
- ☐ Gestational Diabetes
- ☐ Bleeding
- ☐ Herpes
- ☐ Growth Delay
- ☐ Abnormal AFP
- ☐ Abnormal Ultrasound

□ Pregnancy Medications □ HIV

□ Hepatitis

Notes:

_____

_____

_____

BIRTH HISTORY

Problems: (Check all that apply)

□ Fetal Distress □ Premature Rupture of Membranes

□ Infection □ Scalp Bruise

□ Breathing Problems □ C-Section

□ Clavicle Fracture □ Vacuum

□ Intubation □ Maternal Infections

□ NICU Admit □ Preterm Labor

Notes:

_____

_____

_____

SOCIAL HISTORY:

Check one answer for each of the following categories:

Diet: □ Regular □ Vegetarian □ Vegan □ Gluten Free □ Specific □ Carbohydrate

Exercise Level: □ None □ Occasional □ Moderate □ Heavy

Parent's Marital Status: □ Married □ Unmarried □ Separated □ Divorced □ Widowed

Childcare: □ None □ Relative □ Private Sitter □ Daycare/Preschool

Second Hand Smoke Exposure: □ Yes □ No

Seat Belt/Car Seat used Routinely: □ Yes □ No

Does the Patient Smoke? □ Yes □ No