All Star Pediatrics

Where all of our kids shine!!

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MEDICAL HISTORY QUESTIONAIRE

TODAY'S DATE: ____________

PATIENT'S NAME: ____ **DATE OF BIRTH:** ________________

PAST MEDICAL HISTORY (OF THE PATIENT BEING SEEN TODAY)

1. ANY ALLERGIES TO MEDICATIONS? ___ **YES** ___ **NO** NAME OF DRUG ____________________________________

2. ANY SERIOUS ACCIDENTS? ___ **YES** ___ **NO** DATE OF ACCIDENT: ____

3. ANY OPERATIONS? ___ **YES** ___ **NO** DATE AND TYPE OF OPERATION ____________________________________

4. CURRENTLY TAKING ANY MEDICATIONS? ___ **YES** ___ **NO**

KIND OF MEDICATION _________________ DOSAGE (HOW MUCH) __________________________________

5. ANY HOSPITALIZATIONS ___ **YES** ___ **NO** DATES: ____

6. ANY : EAR INFECTIONS? ___ **YES** ___ **NO** PNEUMONIA ___**YES** ___ **NO**

BRONCHITIS? ___ **YES** ___ **NO** URINARY TRACT INFECTION ___**YES** ___ **NO**

FAMILY HISTORY (PLEASE CHECK AND GIVE RELATIONSHIP TO YOUR CHILD)

ALLERGIES/HAY FEVER ___ **YES** ___**NO** THYROID DISEASE ___**YES** ___**NO** CYSTIC FIBROSIS ___ **YES** ___**NO**

KIDNEY DISEASE ___ **YES** ___ **NO** TUBERCULOSIS ___ **YES** ___**NO** BLEEDING DISORDER___ **YES** ___ **NO**

LUNG DISEASE ___ **YES** ___**NO** CANCER-CHILDREN ___**YES** ___ **NO**

HEART DISEASE ___**YES** ___ **NO** CANCER- ADULT)___**YES** __**NO**

MENTAL RETARDATION __**YES** ___ **NO** DIABETES MELLITUS ___**YES** __**NO**

SEIZURES ___ **YES** ___**NO** HEPATITIS A, B, OR C ___**YES** ___**NO**

SOCIAL HISTORY

ANY BROTHERS OR SISTERS? ______**YES** _____ **NO** **(PLEASE LIST THEIR NAMES AND DATE OF BIRTH)**

1. ____ **3.** ____

2. ____ **4.** ____

ARE PARENTS : _______ MARRIED ______ DIVORCED ______ SEPARATED ________ SINGLE

CHILD LIVES WITH : ___MOTHER ___FATHER ___BOTH PARENTS ____GRANDPARENTS ____OTHER _______________

MOTHER'S NAME : ______________________________ DATE OF BIRTH : ___________________AGE AT BIRTH __________

FATHER'S NAME : ______________________________ DATE OF BIRTH: ____________________AGE AT BIRTH __________

BIRTH AND DEVELOPMENT

BIRTH WEIGHT: ____ LBS ____ OZ DELIVERY: ____ VAGINAL _____ CAESAREAN

REASON FOR CAESAREAN : ____

PLACE OF BIRTH (HOSPITAL NAME) ____CITY _________________STATE______

WAS CHILD FULL TERM? ___ **YES** ___ **NO** PREMATURE? ___ **YES** ___ **NO** HOW MANY WEEKS ____________

ANY COMPLICATIONS AT BIRTH? ____

____

WAS OXYGEN NEEDED AT BIRTH? ___ **YES** ___ **NO** WAS CHILD JAUNDICE ___ **YES** ___ **NO**

BLOOD TYPE (IF KNOWN) CHILD ___________ MOTHER _________ FATHER __________

DATE/AGE FIRST WALKED ________________ DATE FIRST/AGE TALKED _________________

NAME OF SCHOOL/DAYCARE ATTENDING ____

ARE THERE ANY OTHER PROBLEMS WE SHOULD KNOW ABOUT? ____

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