Medical History Questionnaire

Pediatric/Family (Birth-12 years)

PriorityHealth®

Date			
Patient Name	Sex (circle one) M F	Date of Birth	Today's Date:
Form Completed By:	Informant (guardian, parent):		Ethnicity:

CHILD'S MEDICAL HISTORY

Has your child ever had:

Allergies (List) (Food or Meds)	☐ No	☐ Yes
Asthma/Wheezing	☐ No	☐ Yes
Asthma Action Plan	☐ No	☐ Yes
Pneumonia	☐ No	☐ Yes
Chicken Pox (Year) _____	☐ No	☐ Yes
Frequent Ear Infections	☐ No	☐ Yes
Vision Problems	☐ No	☐ Yes
Hearing Problems	☐ No	☐ Yes
Skin Problems/Eczema/Hives	☐ No	☐ Yes
TB/Lung Disease	☐ 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	☐ No	☐ Yes
Bladder Infections	☐ No	☐ Yes
Physical or Learning Disabilities	☐ No	☐ Yes
Bleeding Disorders/Hemophilia	☐ No	☐ Ye
Sexually Transmitted Infections	☐ No	☐ Yes
Emotional/Behavioral Problems	☐ No	☐ Yes
Depression/Suicidal Thoughts	☐ No	☐ Yes
Hospitalizations/Surgeries Physical/Sexual Abuse	☐ No	☐ Yes
Emotional Abuse	☐ No	☐ Yes
Bone or Joint Injuries	☐ No	☐ Yes
Dental Problems	☐ No	☐ Yes
Obesity/Overweight	☐ No	☐ Yes
Eating Disorders	☐ No	☐ Yes
Anorexia Nervosa	☐ No	☐ Yes
Bulimia	☐ No	☐ Yes
Learning Disabilities	☐ No	☐ Yes
Attention Deficit Disorder	☐ No	☐ Yes
Lead Poisoning	☐ No	☐ Yes
Vaccines Up-to-Date (√ MCIR)	☐ No	☐ Yes

Other Concerns:

_____

_____

Current Medication(s): (List):

_____

_____

_____

_____

Reviewed by:

FAMILY MEDICAL HISTORY

Has any parent (P), grandparent (GP), aunt (A), uncle (U), sister (S), or brother (B) had:

Allergies (List)	☐ No	☐ Yes	Who?
Asthma/Wheezing	☐ No	☐ Yes	Who?
TB/Lung Disease	☐ No	☐ Yes	Who?
Cystic Fibrosis	☐ No	☐ Yes	Who?
HIV/AIDS	☐ No	☐ Yes	Who?
Suicide Attempts	☐ No	☐ Yes	Who?
Heart Disease	☐ No	☐ Yes	Who?
Sudden Cardiac Death	☐ No	☐ Yes	Who?
High Blood Pressure/Stroke	☐ No	☐ Yes	Who?
High Cholesterol	☐ No	☐ Yes	Who?
Blood Disorders	☐ No	☐ Yes	Who?
Sickle Cell	☐ No	☐ Yes	Who?
Anemia	☐ No	☐ Yes	Who?
Thalassemia	☐ No	☐ Yes	Who?
Clotting Disorders	☐ No	☐ Yes	Who?
Diabetes	☐ No	☐ Yes	Who?
Seizures	☐ No	☐ Yes	Who?
Mental Illness	☐ No	☐ Yes	Who?
Depression	☐ No	☐ Yes	Who?
Suicide Attempts	☐ No	☐ Yes	Who?
Cancer	☐ No	☐ Yes	Who?
Breast	☐ No	☐ Yes	Who?
Cervical	☐ No	☐ Yes	Who?
Colorectal	☐ No	☐ Yes	Who?
Other _____			
Birth Defects	☐ No	☐ Yes	Who?
Hearing Loss	☐ No	☐ Yes	Who?
Speech Problems	☐ No	☐ Yes	Who?
Kidney Disease	☐ No	☐ Yes	Who?
Alcohol/Drug Abuse	☐ 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?
Mental Retardation	☐ No	☐ Yes	Who?
Family Violence	☐ No	☐ Yes	Who?

Other Concerns:

_____

_____

Has any family member ever had an unexplained, unexpected death before age 50?

☐ No ☐ Yes (if yes, describe on back)

Date of Review:

continued >

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PREGNANCY AND BIRTH HISTORY

Adopted	☐ No	☐ Yes
Prenatal care	☐ No	☐ Yes
Illnesses during pregnancy	☐ No	☐ Yes
Medications during pregnancy	☐ No	☐ Yes
Alcohol/drug abuse	☐ No	☐ Yes
Tobacco use	☐ No	☐ Yes
Problems at birth	☐ No	☐ Yes
Mom		
Miscarriage	☐ No	☐ Yes
Toxemia	☐ No	☐ Yes
Baby		
Jaundice	☐ No	☐ Yes
Heart Murmur	☐ No	☐ Yes
Infection	☐ No	☐ Yes
Breathing Problems	☐ No	☐ Yes
Birth Defects	☐ No	☐ Yes

Other:

Name of Hospital: _____

Month of gestation when child was born: _____

Type of delivery: ☐ Vaginal ☐ C-section ☐ VBAC

Birth Weight _____

Discharge Weight _____

Newborn Hearing Screen	☐ No	☐ Yes
Did baby receive Hep B vaccine	☐ No	☐ Yes

Date of Hepatitis B immunization: _____

FEEDING AND DIGESTION

Breast fed ☐ Formula ☐

Severe colic in first 3 months	☐ No	☐ Yes
Feeding problems	☐ No	☐ Yes
Good appetite	☐ No	☐ Yes
Takes vitamins	☐ No	☐ Yes
Eats balanced diet	☐ No	☐ Yes
Constipation problems	☐ No	☐ Yes
Food allergies/issues	☐ No	☐ Yes

PSYCHOSOCIAL HISTORY

Who lives in household: _____

☐ Rent ☐ Own ☐ Shelter

Who cares for child: _____

Is child in daycare: ☐ No ☐ Yes

Type: ☐ Center

☐ Private home

☐ Family member home

Date of Birth:

Mother _____

Father _____

Parents divorced/separated: ☐ No ☐ Yes

Parents working:

Mother	☐ No	☐ Yes
Father	☐ No	☐ Yes

Parents use tobacco:

Mother	☐ No	☐ Yes
Father	☐ No	☐ Yes
Child use tobacco (12 yrs +)	☐ No	☐ Yes
Sleep Problems	☐ No	☐ Yes

Foster Care

Dates: _____ _____

Other Languages _____

MEDICAL HISTORY

Broken bones	☐ No	☐ Yes
Serious accidents	☐ No	☐ Yes
Operations	☐ No	☐ Yes
Hospitalizations	☐ No	☐ Yes
ER visits/Urgent Care	☐ No	☐ Yes

Explain: _____

_____

_____

_____

_____

Additional Information:

_____

_____

_____

_____

_____