Town Center Pediatrics

Today's Date__________

Patient Medical History Questionnaire

Patient's Name: __________ Date of Birth: __________ Age Today: __________

Reason for today's visit: __________

DO YOU HAVE A RECORD OF THIS CHILD'S IMMUNIZATIONS WITH YOU TODAY? Yes / No

Please indicate answers by filling in the blanks, or by circling Yes or No. Answer only the questions, which apply to your child's age.

Mother's Name__________ Birthdate__________
Occupation__________
Cultural background of mother__________
Father's Name__________ Birthdate__________
Occupation__________
Cultural background of father__________
If adults in the household work outside the home, what childcare arrangements are made for this child? __________

PREGNANCY AND BIRTH

Mother's age at birth of child __________
Did mother have any illness during pregnancy? No / Yes
Did she take any medications other than vitamins and iron? No / Yes
Was the baby on time? Yes / No
Was the birth by C-section or vaginal? __________
Obstetrician's name__________
Pediatrician who saw the baby in the hospital__________
What was the birth weight __________ length __________
Did the baby have any trouble starting to breathe? No / Yes
Did the baby have any problems while in the hospital? (Jaundice, infections, other?) No / Yes
What kind? __________
Did the baby receive Hepatitis B vaccine in the nursery? Yes / No

SAFETY/ENVIRONMENT

Do you live in a private house, apartment, mobile home, other? (Circle)
Do you know the hottest temperature of the water in your pipes? Yes / No
Is there a working smoke alarm on each floor in the home? Yes / No
Is there a working fire extinguisher in the home? Yes / No
Does this child always use a car seat / seat belt when in a car? Yes / No
Are there any smokers in the house? No / Yes
Are there any problems with the condition of your home? (Peeling paint, insects, rats or mice) No / Yes
Does your child always wear a helmet when riding a bicycle? Yes / No
Are there pets in the home? No / Yes
If yes, how many and what types? __________

FAMILY HISTORY

Are the child's parents both in good health? Yes / No
Circle any diseases that the child's siblings, parents, grandparents, aunts, uncles, or 1st cousins have: AIDS, alcohol problems, allergies, asthma, blood disorders, cancer, diabetes, drug problems, epilepsy, heart trouble, high blood pressure, high cholesterol, inherited illness, kidney disease, liver disease, lung disease, lupus, mental illness, multiple sclerosis, muscular dystrophy, SIDS, tuberculosis, venereal disease, others.

Use this space to note which relative has which disease:

Have any siblings died? No / Yes
If yes, cause of death__________
Please list:

Siblings Names:	Birthdate:	Sex	General Health (Problems)

Who currently lives in the household?

FEEDING AND NUTRITION:

Current nutrition: breast fed, formula fed, table food. (Circle)
If formula fed, which one?__________ Amount__________oz
If on regular milk, which? Whole, 2%, 1% Amount/day__________
Is your child's appetite usually good? Yes / No
Is it good now? Yes / No
Was there severe colic or any other unusual feeding problems during the first three months? No / Yes
Do any foods disagree with him/her? No / Yes
For the first 6 months was this child breast fed or bottle fed? (Circle)
Does s/he take vitamins / fluoride? No / Yes
Which ones? __________

DEVELOPMENT/BEHAVIOR

At what age did this child sit alone? __________
At what age did s/he walk alone? __________
Did s/he say any words by the 18months of age? Yes / No
How does this child compare to others his or her age? Same, Advanced, Behind (Circle one)
Are there any problems with sleeping? No / Yes
What grade is this child in? __________
Has s/he had any trouble with school? No / Yes
Does s/he get along well with other children? Yes / No
If your child has had any of the following, please circle: Nail biting, thumb sucking, bed wetting, bad temper, problems with toilet training, hyperactivity, nightmares, speech problems, problems with discipline, others:__________

PAST MEDICAL HISTORY

Where has your child gone for check-ups until now?
____
Date of last check up: __________
Date of last dental check-up: __________
Has your child had any allergic reactions to any medications foods, or insect bites No / Yes
Which ones__________
Has your child had a bad reaction to any Immunizations? No / Yes
Which ones__________
Any hospitalizations/surgeries other than for birth? No / Yes
For what? __________
Any serious injuries / broken bones / stitches? No / Yes
What kind? __________
Are any medications taken regularly? No / Yes
Which ones?__________

REVIEW OF SYSTEMS

Has your child had frequent ear infections? No / Yes
Any hearing problems? No / Yes
Any vision problems? No / Yes
Has s/he had any problems with teeth? No / Yes
Does this child have frequent colds or sore throat? No / Yes
Does s/he have a history of allergies, asthma, pneumonia, bronchitis or recurrent cough? (Circle any, which are yes.) No / Yes
Does s/he have a heart murmur or any heart problem? No / Yes
Any problems with kidneys, bladder or urination? No / Yes
Any problems with diarrhea or constipation? No / Yes
Have there been any convulsions or other problems with the nervous system? No / Yes
Any eczema, hives or other skin conditions? No / Yes
Has your child ever been anemic? No / Yes
Has your child ever seen a Specialist? No / Yes
If yes, for what problem (s)__________