Phillips Pediatrics

Medical History Questionnaire

Patient's Name:_____ D.O.B.:_____/_____/_____ Today's Date: _____/_____/_____

HOUSEHOLD

Please list all those living in child's home.

Name:	Relationship to Child:	Name	Relationship to Child:
1.		5.	
2.		6.	
3.		7.	
4.		8.	

BIRTH HISTORY

Birth Weight:_____

Born at which hospital?_____

Was the baby born in the United States: ☐ Yes ☐ No

Was the baby born at term?_____ Early? ☐ Late? ☐

Did the mother have any illness with her pregnancy? ☐ Yes ☐ No

Explain:_____

During the pregnancy, did mother smoke ☐ Yes ☐ No

Drink alcohol ☐ Yes ☐ No | Use drugs or medications ☐ Yes ☐ No

What?_____ When?_____

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why?_____

If NO, please list birth country: _____

Did your baby have any problems right after birth?

☐ Yes ☐ No Explain:_____

Did your baby go home with the mother from the hospital?

☐ Yes ☐ No Explain:_____

GENERAL

Do you consider your child to be in good health? ☐ Yes ☐ No Explain: _____

Does your child have any serious illness or medical condition? ☐ Yes ☐ No Explain: _____

Has your child had serious injuries or accidents? ☐ Yes ☐ No Explain: _____

Has your child had any surgery? ☐ Yes ☐ No Explain: _____

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain: _____

Any admissions to a hospital? ☐ Yes ☐ No Explain: _____

DEVELOPMENT

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain: _____

Are you concerned about your child's emotional development? ☐ Yes ☐ No Explain: _____

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain: _____

If your child is in school:

List school: _____ Grade: _____

How is his/her behavior in school? _____

Has he/she failed/repeated a grade in school? ☐ Yes ☐ No _____ Is he/she in special or resource classes? ☐ Yes ☐ No

How is he/she doing in academic subjects? _____

Does your child have any special healthcare needs, personality traits, strengths, or weaknesses you would like us to know about?

☐ Yes ☐ No Explain: _____

Complete Family & Child History on page 2

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FAMILY HISTORY (First degree relative: parent, grandparent, aunt, uncle, sibling(s))

Deafness	☐ Yes ☐ No	Who:	Comments:
Dental Cavities	☐ Yes ☐ No	Who:	Comments:
Nasal allergies	☐ Yes ☐ No	Who:	Comments:
Asthma	☐ Yes ☐ No	Who:	Comments:
Tuberculosis	☐ Yes ☐ No	Who:	Comments:
Eczema	☐ Yes ☐ No	Who:	Comments:
Heart disease (before 50)	☐ Yes ☐ No	Who:	Comments:
High blood pressure (before 50)	☐ Yes ☐ No	Who:	Comments:
High cholesterol	☐ Yes ☐ No	Who:	Comments:
Sudden cardiac death	☐ Yes ☐ No	Who:	Comments:
Anemia	☐ Yes ☐ No	Who:	Comments:
Bleeding disorder	☐ Yes ☐ No	Who:	Comments:
Liver disease	☐ Yes ☐ No	Who:	Comments:
Kidney disease	☐ Yes ☐ No	Who:	Comments:
Diabetes (before 50)	☐ Yes ☐ No	Who:	Comments:
Bed-wetting (after 10)	☐ Yes ☐ No	Who:	Comments:
Epilepsy or convulsions	☐ Yes ☐ No	Who:	Comments:
Sudden infant death syndrome	☐ Yes ☐ No	Who:	Comments:
Alcohol abuse	☐ Yes ☐ No	Who:	Comments:
Drug abuse	☐ Yes ☐ No	Who:	Comments:
Tobacco use (vape, cigarette, etc.)	☐ Yes ☐ No	Who:	Comments:
Depression	☐ Yes ☐ No	Who:	Comments:
Anxiety	☐ Yes ☐ No	Who:	Comments:
ADHD	☐ Yes ☐ No	Who:	Comments:
Other Mental Illness	☐ Yes ☐ No	Who:	Comments:
Intellectual Disability	☐ Yes ☐ No	Who:	Comments:
HIV or AIDS	☐ Yes ☐ No	Who:	Comments:
Immunosuppression	☐ Yes ☐ No	Who:	Comments
Additional family history	☐ Yes ☐ No	Who:	Comments:

CHILD HISTORY

Does your child have, or has he/she ever had:

Frequent ear infections	☐ Yes ☐ No	Explain:
Problems with ears or hearing	☐ Yes ☐ No	Explain:
Nasal allergies	☐ Yes ☐ No	Explain:
Problems with eyes or vision	☐ Yes ☐ No	Explain:
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes ☐ No	Explain:
Any heart problem or heart murmur	☐ Yes ☐ No	Explain:
Anemia or bleeding problem	☐ Yes ☐ No	Explain:
Blood transfusion	☐ Yes ☐ No	Explain:
Frequent abdominal pain	☐ Yes ☐ No	Explain:
Constipation requiring doctor visits	☐ Yes ☐ No	Explain:
Bladder or kidney infection	☐ Yes ☐ No	Explain:
Bed-wetting (after 5)	☐ Yes ☐ No	Explain:
(For girls) Has she started her menstrual periods?	☐ Yes ☐ No	Explain:
(For girls) Are there problems with her periods?	☐ Yes ☐ No	Explain:
Eczema or other recurrent skin problems?	☐ Yes ☐ No	Explain:
Frequent headaches	☐ Yes ☐ No	Explain:
Seizures or other neurological problems:	☐ Yes ☐ No	Explain:
Convulsions or other neurologic problems	☐ Yes ☐ No	Explain:
Diabetes	☐ Yes ☐ No	Explain:
Thyroid or other endocrine problem	☐ Yes ☐ No	Explain:
Immunosuppression	☐ Yes ☐ No	Explain:
Use of alcohol or drugs	☐ Yes ☐ No	Explain:
Additional child history	☐ Yes ☐ No	Explain: