Children's Choice Pediatrics

Child's Name:_____ Date of Birth:_____

FAMILY HISTORY QUESTIONNAIRE

Please check YES or NO if anyone in the child's immediate family has or had the following conditions. In the 3rd column please note which family member has or had the condition.
MGM=Maternal Grand Mother MGF=Maternal Grand Father PGM=Paternal Grand Mother PGF=Paternal Grand Father
A= Aunt U=Uncle M=Mother F=Father S=Sibling

CONDITION	YES	NO	Family Member	CONDITION	YES	NO	Family Member
Birth Defect				Hearing Problems Before Age 50			
Sudden Infant Death				Recurrent Ear Infections			
Cancer				Muscle Disease			
Thyroid Problems				Back/Hip Problems Before Age 50			
Diabetes				Arthritis/Joint Problem Before Age 50			
Allergy/Hay Fever				Brain or Nerve Disease/Seizures			
Eczema/Recurrent Rash				Slow Development			
Asthma				Learning Disability			
Cystic Fibrosis				Emotional/Behavioral Problems			
Heart Disease/Stroke Before Age 50				Hyperactivity/Inattention			
High Cholesterol				Sexually Transmitted Disease			
High Blood Pressure				Alcohol/Drug/Substance Abuse			
Bleeding Disorder				AIDS/Tuberculosis/Hepatitis			
Anemia				Sexual Abuse			
Kidney/Bladder Problems				Physical Abuse			
Stomach/Bowel Problems				Pets in The Home			
Eye Problems				Smokers in the Home			

CHILD'S MEDICAL QUESTIONNAIRE

PREGNANCY PROBLEMS	YES	NO	PREGNANCY PROBLEMS	YES	NO
Bleeding During Pregnancy			Drank Alcohol		
Gained 30 or More Pounds			Smoked Cigarettes		
Gained 15 or Less Pounds			Cesarean Section (C) or Vaginal Birth (V)	C	V
Had to Take Medications			Difficult Delivery		
Hurt or Injured			Used Drugs (illegal)		

Any Other Pregnancy Problems: Birth Hospital:

Length of Pregnancy: _____ Weeks Birth Weight:_____Lbs. _____Oz. Length:_____In.

NEWBORN/INFANT PROBLEMS	YES	NO	NEWBORN/INFANT PROBLEMS	YES	NO
Trouble Breathing			Given Any medications		
Needed Oxygen/Turned Blue			Had Seizure (fits/convulsions)		
Jaundiced (turned yellow)			Was Jittery		
Was a Multiple			Feeding problems/Vomiting		
Had an Infection			Birth Defect		
			Hospitalized More Than 7 Days		

Any Other Newborn/Infant Problems:

HEALTH PROBLEMS	YES	NO	HEALTH PROBLEMS	YES	NO
Allergies/Sensitivities			Kidney/Urinary Problems		
Rashes/Skin Problems			Bowel Problems		
Ear Infections			Slow Weight Gain		
Trouble Hearing			Anemia		
Trouble With Eyes/Vision			Poisoning/Overdose		
Seizures/Convulsions/Spells			Serious Injury		
Meningitis			Hospitalized		
Sinusitis			Surgeries/Operations		
Pneumonia			Immunizations Up to Date		
Asthma			Heart Problems		

Any Other Illness/Disorders:

Explain Any "Yes" Answers:

Current Medications:	Allergies (drug, food, other):

Provider Signature:_____ Date:_____