

Original Date:

MEDICAL HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient's Name	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Mother's Name		DOB:
Father's Name		DOB:
List All Siblings		
BIRTH HISTORY		

Type of Delivery: Vaginal Cesarean Full-term Premature Weeks Gestation

Please List Any Birth Complications:

Name of Hospital: _____ Hep B given at Birth Yes No Newborn Hearing Screen Yes No

Birth Weight: _____ lbs. _____ oz. Discharge Weight: _____ lbs _____ oz. Length: _____ Head Circumference _____ Apgars _____

Breastfeeding Yes No Formula Type _____

FAMILY & ENVIRONMENTAL HISTORY (Please List Details)	
Family History:	<input type="checkbox"/> Hypertension/Cholesterol Risk/Heart Problems _____
	<input type="checkbox"/> Cancer _____ <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Seizures _____
	<input type="checkbox"/> Allergies _____ <input type="checkbox"/> Asthma/Respiratory Problems _____
	<input type="checkbox"/> Headaches _____ <input type="checkbox"/> Depression/Mental Health/Academic Issues _____
	<input type="checkbox"/> Anemia/blood disorders _____
	<input type="checkbox"/> Other _____ <input type="checkbox"/> None of these Conditions exist
Environmental History:	Does anyone smoke in your house? _____ Do you have any pets (please list) _____
	Was your home built before 1970? _____

PATIENT MEDICAL HISTORY (Please List Details)	
<input type="checkbox"/> Allergies	
<input type="checkbox"/> Chicken Pox	
<input type="checkbox"/> Hospitalizations/Surgeries	
<input type="checkbox"/> Illnesses/Chronic Conditions	
<input type="checkbox"/> Other	

