Medical Park Pediatrics

Medical History Questionnaire

5 to 17 Years

STICKER HERE

Demographics

Child's name_____ Adopted/foster care? ☐Y ☐N

Parent names_____Parents married? ☐ Y ☐N

Siblings names and ages _____

Others living in the home _____ Smokers in household? ☐ Y ☐ N

School and grade_____ Sports/Interests_____

Birth History

Place of birth_____ Birth weight_____

Premature? ☐ N ☐Y (How many weeks?_____)

Problems after birth? _____

Name and Location of Prior Medical Provider

_____

Family Health History

(which family member)

Asthma/allergy_____

Depression/anxiety/suicide_____

ADHD_____

Diabetes_____

Sudden heart death_____

Death before age 50_____

Delayed development_____

Serious childhood illness_____

Other_____

Medications/ Allergies/ Immunizations

Medications_____

Vitamins/supplements_____

Medication allergies (specify reaction)_____

Immunizations up-to-date? ☐Y ☐ N ☐not sure

Personal Health History (please indicate if your child has a history of any of the following)

Skin

☐cold sores
☐eczema
☐acne

Ear, Eye, Nose, Throat

☐trouble seeing/glasses
☐lazy eye (strabismus)
☐hearing loss
☐frequent ear infections
☐frequent throat infections

Respiratory

☐asthma
☐pneumonia

Allergy/Immune system

☐Seasonal/environmental allergy_____
☐Food allergy_____
☐Anaphylaxis

Gastrointestinal

☐Reflux disease
☐Frequent constipation

Cardiac

☐Heart disease or surgery

Genitourinary

☐Urinary tract infection

Neurologic

☐Seizures or epilepsy
☐Concussion/head injury

Developmental/Behavioral/Mood

☐Autism
☐Speech delay
☐Attention problems
☐Depression or anxiety

Other illnesses_____

Hospitalizations_____

Surgery_____