



Medical History Questionnaire

Birth to 4 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
 Daycare or preschool? Y N (School Name _____) Pets in home _____

Birth History

Place of birth _____ Birth weight _____
 Problems during pregnancy _____
 Premature? N Y (How many weeks? _____)
 Birth method vaginal c-section
 Problems after birth? _____

Family Health History

(which family member)

Asthma/allergy _____
 Birth defect _____
 Delayed development _____
 Diabetes _____
 Sudden heart death _____
 Death before age 50 _____
 Depression/anxiety _____
 Serious childhood illness _____
 Other _____

Name and Location of Prior Medical Provider

Medications/ Allergies/ Immunizations

Medications _____
 Vitamins/supplements _____
 Medication allergies: _____
 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
- frequent diaper rash

Allergy/Immune system

- Seasonal/environmental allergy _____
- Food allergy _____
- Anaphylaxis

Neurologic

- Seizures or epilepsy
- Concussion/head injury

Ear, Eye, Nose, Throat

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

Gastrointestinal

- Reflux disease
- Frequent constipation

Developmental/Behavioral

- Autism
- Growth delay
- Speech delay
- Other issues _____

Respiratory

- asthma
- pneumonia

Cardiac

- Heart disease or surgery

Other illness

Hospitalizations

Surgery

Genitourinary

- Urinary tract infection