Medical History Questionnaire – AGE 0-4

Medical Park Family Care, Inc.

STICKER HERE

Names of parents:_____
Marital status of parents:_____
Child adopted or in foster care? ☐No ☐Yes
(describe):_____
Siblings (names and ages):_____
_____
Others living in home:_____ **Smokers in household?** ☐No ☐Yes
Daycare or preschool? ☐No ☐Yes Name:_____

Medications:_____
_____
Vitamins:_____
Medicine allergies (Specify reaction):_____
_____
Are immunizations up to date? ☐No ☐Yes
Name, city, state of prior health provider:
_____

FAMILY HISTORY (specify WHICH family member and AGE of diagnosis):
Asthma:_____
Birth defects:_____
Diabetes:_____
Congenital heart disease:_____
Sudden cardiac death:_____
Childhood cancer (specify type):_____
Other serious childhood illnesses: _____

BIRTH HISTORY Problems during pregnancy:_____
Birth Weight:_____ Premature? ☐No ☐Yes (Gestational age in weeks:_____)
Birth location:_____ Birth Method: ☐Vaginal ☐ C-section
Problems after birth:_____

PERSONAL HEALTH HISTORY Please indicate if your child has a history of any of the following:

Skin
☐ Cold sores
☐ Eczema
☐ Diaper rash, frequent

Eye, Ear, Nose, Throat
☐ Visual impairment
☐ Strabismus (lazy eye)
☐ Hearing loss
☐ Ear infections, frequent

Respiratory
☐ Asthma
☐ Pneumonia

Gastrointestinal
☐ Reflux disease (GERD)
☐ Constipation, frequent

Allergy, Immune
☐ Seasonal or environmental allergies
☐ Other allergies (specify):_____
☐ Anaphylaxis
☐ Urticaria (hives), frequent
☐ Varicella infection (Chicken pox)

Heart, Vascular, Endocrine
☐ Heart disease or surgery

Genitourinary
☐ Urinary tract infection

Musculoskeletal
☐ Broken bones (specify locations):_____
_____
☐ Gait problems (specify):_____

Neurological
☐ Seizures or epilepsy
☐ Head injury (specify age):_____

Developmental
☐ Autism or Asperger's syndrome
☐ Growth delay
☐ Speech delay
☐ Other developmental delay

OTHER ILLNESSES: _____
_____

SURGERIES (include age): _____
_____