

MEDICAL HISTORY QUESTIONNAIRE



THE CENTER FOR
ADVANCED
PEDIATRICS

Name _____
 Birth Date _____ Age _____ M F
 Form Completed by _____ Date Completed _____

HOUSEHOLD

Please list all those living in child's home.

Name	Relationship to	Date of Birth	Health Problems

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home?

BIRTH HISTORY

Birth weight _____

Born at which hospital? _____

Was the baby born at term? _____ Early? _____ Late? _____

Did the mother have any or illness with her pregnancy? Yes No
 Explain _____

During the pregnancy, did mother smoke Yes No

Drink alcohol Yes No Use drugs or medications Yes No

What? _____ When? _____

Was the delivery Vaginal? Cesarean?

If cesarean, why? _____

Did your baby have any problems right after birth?

Yes No Explain _____

Did your baby go home with the mother from the hospital?

Yes No Explain _____

GENERAL

Do you consider your child to be in good health? Yes No Explain _____

Does your child have any serious illness or medical condition? Yes No Explain _____

Has your child had serious injuries or accidents? Yes No Explain _____

Has your child had any surgery? Yes No Explain _____

Is your child allergic to any medicines or drugs? Yes No Explain _____

Any admissions to a hospital? Yes No Explain _____

DEVELOPMENT

Are you concerned about your child's physical development? Yes No Explain _____

Are you concerned about your child's mental or emotional development? Yes No Explain _____

Are you concerned about your child's attention span? Yes No Explain _____

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____