Rastogi, Winkle, and Yim, M.D.
MEDICAL/FAMILY HISTORY QUESTIONNAIRE

Patient's Name _____ Date of Entry _____

Phone No. _____ Date of Birth _____

Source of Information _____ Relationship _____

MOTHER'S PREGNANCY/CHILD BIRTH HISTORY:
(under 2 years old)

Illnesses during pregnancy	No	Yes
Any Medications during pregnancy	No	Yes
Alcohol/Drug Abuse	No	Yes
Problems at birth	No	Yes

Describe: _____

Type of delivery - ❑ Vaginal ❑ C-section

Birth weight _____ Discharge weight _____

Did baby receive Hepatitis B vaccine	No	Yes

Date of Hepatitis B immunization: _____

Name of Hospital: _____

Was first PKU done	No	Yes

PATIENT'S HEALTH HISTORY: Has your child ever had...

Measles/Mumps/Chicken Pox	No	Yes
Frequent ear infections	No	Yes
Vision/Hearing problems	No	Yes
Skin problems		
Asthma/Allergies	No	Yes
TB/Lung Disease/Croup	No	Yes
Seizures/Epilepsy	No	Yes
High Blood Pressure	No	Yes
Heart Defects/Disease	No	Yes
Liver Disease/Hepatitis	No	Yes
Diabetes	No	Yes
Kidney Disease/Bladder Infections	No	Yes
Handicaps/Disabilities	No	Yes
Bleeding Disorders/Hemophilia	No	Yes
Sexually Transmitted Diseases	No	Yes
Emotional Problems/Suicide Attempts	No	Yes
Hospitalization/Surgeries	No	Yes
Physical/Emotional Abuse/Broken Bones	No	Yes

SOCIAL HISTORY:

How many living in the household? _____

Who cares for the child? _____

Who lives in household? _____

_____

School _____

Grade _____ Report Card _____

School behavior problems? _____

FAMILY HISTORY: Has anyone in the family (parents, grandparents, aunts/uncles, sisters/brothers, cousins, etc..) had the following:

			Who
TB/Lung Disease	No	Yes	_____
HIV/AIDS	No	Yes	_____
Suicide Attempts	No	Yes	_____
Heart Disease	No	Yes	_____
High Blood Pressure	No	Yes	_____
High Cholesterol	No	Yes	_____
Blood Disorders	No	Yes	_____
Diabetes	No	Yes	_____
Seizures	No	Yes	_____
Allergies/Asthma	No	Yes	_____
Mental Retardation	No	Yes	_____
Cancer	No	Yes	_____
Birth Defects	No	Yes	_____
Hearing/Speech problems	No	Yes	_____
Kidney Disease	No	Yes	_____
Alcohol/Drug Abuse	No	Yes	_____
Stroke	No	Yes	_____
Hepatitis/Liver Disease	No	Yes	_____
Thyroid Disease	No	Yes	_____
Learning Problems	No	Yes	_____
Attention Deficit Disorder	No	Yes	_____
Family Violence	No	Yes	_____

ADOLESCENT HISTORY: (interview separately)

Age at first period _____ LMP _____

Sexually Active ❑ No ❑ Yes # of partners _____

Sex of partners: M / F

Any fears of partner / other violence? ❑ No ❑ Yes

Smoker ❑ No ❑ Yes Alcohol Use ❑ No ❑ Yes

Drug Use ❑ No ❑ Yes Working ❑ No ❑ Yes

Do you think about hurting yourself ❑ No ❑ Yes

Access to gun/weapon ❑ No ❑ Yes

Provider: _____

Date: _____

Comments: _____

_____

_____

Updates: _____ / _____ / _____ / _____ / _____ / _____ / _____ / _____ / _____ /