# Maryland Healthy Kids Program
# Medical/Family History Questionnaire

| Patient Name: | Date of Birth: | Sex: (circle) Male Female |
|---|---|---|
| Form Completed By: / Today's Date | Relationship: | |

## PREGNANCY AND BIRTH HISTORY

Name of Hospital: _____
Illnesses during pregnancy? No ☐ Yes ☐
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:_____
Newborn Hearing Screen? No ☐ Yes ☐

## PSYCHOSOCIAL HISTORY

Who lives in household?_____
_____
How many?_____
☐ Rent? ☐ Own? ☐ Shelter?
Who cares for child?_____
Date of Birth? Mother_____
Father_____
Are parents working? Mother No ☐ Yes ☐
Father No ☐ Yes ☐
Foster Care? _____Dates:_____
Other Languages?_____

## FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

| | | | Who? |
|---|---|---|---|
| Allergies (List) _____ | No ☐ | Yes ☐ | _____ |
| Asthma | No ☐ | Yes ☐ | _____ |
| TB/Lung Disease | No ☐ | Yes ☐ | _____ |
| HIV/AIDS | No ☐ | Yes ☐ | _____ |
| Suicide Attempts | No ☐ | Yes ☐ | _____ |
| Heart Disease | No ☐ | Yes ☐ | _____ |
| High Blood Pressure/Stroke | No ☐ | Yes ☐ | _____ |
| High Cholesterol | No ☐ | Yes ☐ | _____ |
| Blood Disorders/Sickle Cell | No ☐ | Yes ☐ | _____ |
| Diabetes | No ☐ | Yes ☐ | _____ |
| Seizures | No ☐ | Yes ☐ | _____ |
| Mental Illness | No ☐ | Yes ☐ | _____ |
| Cancer | No ☐ | Yes ☐ | _____ |
| Birth Defects | No ☐ | Yes ☐ | _____ |
| Hearing Loss | No ☐ | Yes ☐ | _____ |
| Speech Problems | No ☐ | Yes ☐ | _____ |
| Kidney Disease | No ☐ | Yes ☐ | _____ |
| Alcohol/Drug Abuse | No ☐ | Yes ☐ | _____ |
| Hepatitis/Liver Disease | | | |
| Thyroid Disease | No ☐ | Yes ☐ | _____ |
| Learning Problems/Attention Deficit Disorder | No ☐ | Yes ☐ | _____ |
| Family Violence | No ☐ | Yes ☐ | _____ |

Other: _____
_____

## MEDICAL HISTORY

Has your child ever had:

| | | |
|---|---|---|
| Allergies (List) _____ | No ☐ | Yes ☐ |
| Asthma | No ☐ | Yes ☐ |
| Chicken Pox (Year) ___ | No ☐ | Yes ☐ |
| Frequent Ear Infections | No ☐ | Yes ☐ |
| Vision/Hearing Problems | No ☐ | Yes ☐ |
| Skin Problems/Eczema | No ☐ | Yes ☐ |
| TB/Lung Disease | 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 ☐ |
| Physical or Learning Disabilities | No ☐ | Yes ☐ |
| Bleeding Disorders/Hemophilia | No ☐ | Yes ☐ |
| Sexually Transmitted Diseases | No ☐ | Yes ☐ |
| Emotional or Behavioral Problems | No ☐ | Yes ☐ |
| Depression/Suicidal Thoughts | No ☐ | Yes ☐ |
| Hospitalizations/Surgeries | No ☐ | Yes ☐ |
| Physical/Emotional/ Sexual Abuse | No ☐ | Yes ☐ |
| Bone or Joint Injuries | No ☐ | Yes ☐ |
| Obesity/Eating Disorders | No ☐ | Yes ☐ |
| Other: _____ | No ☐ | Yes ☐ |

Current Medication(s): (*List*) _____
_____

| Reviewed by: | Date of Review: |
|---|---|