Premier Pediatrics of Manassas

Medical History Questionnaire

Name of Patient:_____

DOB:_____ MALE[ ] FEMALE [ ] Date: _____

Form Completed by:_____ Relationship:_____

FAMILY HISTORY (Please list all family members in your household.)

Name	Relationship	DOB	Health Problems

PARENTS: Married [ ] Divorced [ ] Separated [ ] Single [ ]
If separated/ divorced, who has custody of the patient? _____
Are there any siblings living away from home? Yes [ ] No [ ]
If yes, give name, age and where they live: _____

SOCIAL HISTORY

	Yes	No	If yes, comment
Does your child go to daycare?			
Does your child go to school?			
Does anyone in your family smoke?			
Does your family have any pets?			
Do you have smoke alarms in your home?			
Does your family wear seatbelts/ car seats?			
Are there guns in the home?			
If so, are they stored in a safe place?			

PAST MEDICAL HISTORY

	Yes	No	If yes, comment
Is your child allergic to any medications, foods, environmental items or contactants?			
Has your child ever been hospitalized?			
Has your child had any surgery?			
Does your child have any developmental problems?			
Does your child have any serious medical conditions or chronic issues?			
Has your child had any serious accidents or injuries?			
Is your child behind on vaccines?			
Is your child on any medications? (Over the counter or prescriptions)			

Family History (Any parents, siblings, or grandparents who have the following?)

	Yes	No	Relationship		Yes	No	Relationship
Allergies				Eye Problems			
Asthma				Hearing Problems			
Heart Disease				Mental Illness			
High Cholesterol				Seizure Disorder			
Diabetes				Cancer			
Thyroid Disease				Birth Defects			
Anemia				Tuberculosis			
Kidney Disease				Drug or Alcohol Abuse			
Liver Disease				Bleeding Disorders			
Immune Problems				Eczema			
Gastrointestinal							

If yes to any of the above, please explain briefly:

_____

_____

_____

REVIEW OF SYSTEMS (Does your child have any of the following problems or concerns?)

	Yes	No	If yes, comment		Yes	No	If yes, comment
Asthma/ Wheezing				Skin Problems			
Anemia				Seizures			
Vision or Eyes				Frequent Headaches			
Ear infections				Diabetes			
Nasal Problems				Thyroid Problems			
Heart/ Murmurs				Bleeding Disorder			
Liver Problems				Chicken Pox			
High Blood Pressure				Developmental Issues			
Pneumonia				Attention Problems			
Abdominal Pain				Sleep Issues			
Constipation				Blood in Stool			
Joint Pain/ Swelling				Allergies			
Broken Bones				Menstrual Problems			
Bladder/ Kidney Problems				Drug or Alcohol Use			
Frequent Strep Throat				Other			
Hearing Problems				Other			
Bedwetting/ Soiling				Other			

Extra Comments:

_____

_____

_____

_____ _____

Signature **Date**