Melissa Levine, M.D. **Laura Lieberman, M.D.** **Keun Hee Oh, M.D.**

MEDICAL/FAMILY HISTORY QUESTIONNAIRE

Patient Name:	Date of Birth:
Form Completed by: Relationship:	Today's Date:

PREGNANCY AND BIRTH HISTORY

Name of Hospital_____

Illnesses during pregnancy? Yes No
Medications during pregnancy? Yes No
Alcohol/Drug use? Yes No
Problems at birth? Yes No
Describe_____
Type of Delivery? Vaginal C-section
Birth Wt_____ Discharge Wt _____
Did baby receive Hepatitis B vaccine? Yes No
Date of Hepatitis B immunization _____
Passed hearing screen? Yes No

PSYCHOSOCIAL HISTORY

Who lives in the household?
_____
_____
_____

Are there any smokers in the home? Yes No

Is there a gun in the home? Yes No

Are there pets? Yes No

Is your child(ren) in daycare? Yes No

FAMILY HISTORY

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

			Who?
TB/Lung Disease	Yes	No	_____
HIV/AIDS	Yes	No	_____
Suicide Attempts	Yes	No	_____
Heart Disease	Yes	No	_____
High Blood Pressure/Stroke	Yes	No	_____
Blood Disorders/Sickle Cell	Yes	No	_____
Diabetes	Yes	No	_____
Seizures	Yes	No	_____
Allergies	Yes	No	_____
Mental Illnesses	Yes	No	_____
Cancer	Yes	No	_____
Birth Defects	Yes	No	_____
Hearing/Speech Problems	Yes	No	_____
Kidney Disease	Yes	No	_____
Alcohol/Drug Use	Yes	No	_____
Hepatitis/Liver Disease	Yes	No	_____
Thyroid Disease	Yes	No	_____
Learning Problems/ADD	Yes	No	_____
Family Violence	Yes	No	_____
Gastrointestinal Disease	Yes	No	_____
Sudden Death	Yes	No	_____

Other: _____
_____

HEALTH HISTORY

Has your child ever had:

Chicken pox	Yes	No
Frequent Ear Infections	Yes	No
Vision/Hearing Problems	Yes	No
Skin Problems/Eczema	Yes	No
Asthma/Allergies	Yes	No
TB/Lung Disease	Yes	No
Seizure/Epilepsy	Yes	No
High Blood Pressure	Yes	No
Heart Defects/Disease	Yes	No
Liver Disease/Hepatitis	Yes	No
Diabetes	Yes	No
Kidney Disease/Hepatitis	Yes	No
Physical or Learning Disabilities	Yes	No
Bleeding Disorders/Hemophilia	Yes	No
Sexually Transmitted Disease	Yes	No
Emotional or Behavioral Problems	Yes	No
Physical/Emotional/Sexual Abuse	Yes	No
Bone or Joint Injuries	Yes	No
Obesity/Eating Disorders	Yes	No

Other:_____
Hospitalization/Surgeries _____
(include dates) _____
_____
Current Medications _____
_____
_____
Medicine Allergies _____
_____

Reviewed by _____ Date Reviewed_____