SOUTH TEXAS CENTER FOR PEDIATRIC CARE

Medical History Questionnaire

Date:	Patient Name:	Date of Birth:	Sex (circle one) M F
Form Completed By: (Name and Relationship)	Contact No Phone: Cell No:	Email:	
Ethnicity: *(check one)* Hispanic or Latino ☐ Not Hispanic or Latino ☐			
Race : *(check one)* ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race ☐ American Indian or Alaska Native			

CHILD MEDICAL HISTORY

Vaccines Up-to-Date ☐ No ☐ Yes

Allergies (List) (Food or Meds) ☐ No ☐ Yes

____

Current Medication(s) (List) ________________________

____

Has your child ever had any of the following:

ADHD/ADD		☐ No	☐ Yes
Asthma/Wheezing		☐ No	☐ Yes
Autism		☐ No	☐ Yes
Behavioral Problems		☐ No	☐ Yes
Bleeding Problems		☐ No	☐ Yes
Bone or Joint Injuries		☐ No	☐ Yes
Broken Bones		☐ No	☐ Yes
Chicken Pox (Year) _________		☐ No	☐ Yes
Childhood Cancer		☐ No	☐ Yes
Chronic Illness		☐ No	☐ Yes
Dental Problems		☐ No	☐ Yes
Depression/Suicidal Thoughts		☐ No	☐ Yes
Diabetes		☐ No	☐ Yes
Eating Disorders		☐ No	☐ Yes
Frequent Ear Infections		☐ No	☐ Yes
Hearing Problems		☐ No	☐ Yes
Heart Defects/Disease		☐ No	☐ Yes
Hospitalizations		☐ No	☐ Yes
High Blood Pressure		☐ No	☐ Yes
Kidney Disease/Bladder Infections		☐ No	☐ Yes
Lead Poisoning		☐ No	☐ Yes
Learning Problems/Problems in school		☐ No	☐ Yes
Liver Disease/Hepatitis		☐ No	☐ Yes
Obesity/Overweight		☐ No	☐ Yes
Physical Disabilities		☐ No	☐ Yes
Problems in School		☐ No	☐ Yes
Pneumonia		☐ No	☐ Yes
Seizures/Epilepsy		☐ No	☐ Yes
Serious accidents		☐ No	☐ Yes
Sexually Transmitted Infections	☐ NA	☐ No	☐ Yes
Skin Problems		☐ No	☐ Yes
Speech Delay		☐ No	☐ Yes
Surgery		☐ No	☐ Yes
Vision Problems		☐ No	☐ Yes

Other Medical Problems: ________________________

____

ER visits/Urgent Care ☐ No ☐ Yes

(How many in last 12 months?)________________________

Explain: ____

FAMILY MEDICAL HISTORY

Has any parent (P), grandparent (GP), aunt (A), uncle (U), sister (S), brother (B) cousin (C) had any of the following:

Alcohol/Drug Abuse	☐ No	☐ Yes
Anemia	☐ No	☐ Yes
Arthritis	☐ No	☐ Yes
Asthma/Wheezing	☐ No	☐ Yes
Attention Deficit Disorder	☐ No	☐ Yes
Birth Defects	☐ No	☐ Yes
Cancer	☐ No	☐ Yes
Cystic Fibrosis	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Easy Bruising/Bleeding	☐ No	☐ Yes
Eating Disorders	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
Family Violence	☐ No	☐ Yes
Hearing Loss	☐ No	☐ Yes
Heart Disease	☐ No	☐ Yes
Hepatitis/ Liver Disease	☐ No	☐ Yes
High Blood Pressure	☐ No	☐ Yes
High Cholesterol	☐ No	☐ Yes
HIV/AIDS	☐ No	☐ Yes
Kidney Disease	☐ No	☐ Yes
Learning Problems	☐ No	☐ Yes
Lung Disease	☐ No	☐ Yes
Mental Illness	☐ No	☐ Yes
Mental Retardation	☐ No	☐ Yes
Obesity	☐ No	☐ Yes
Postpartum Depression	☐ No	☐ Yes
Seizures	☐ No	☐ Yes
Sickle Cell	☐ No	☐ Yes
Speech Problems	☐ No	☐ Yes
Stroke	☐ No	☐ Yes
Suicide Attempts	☐ No	☐ Yes
Thyroid Disease	☐ No	☐ Yes
TB	☐ No	☐ Yes

Has any family member ever had an unexplained, unexpected death before age 50? ☐ No ☐ Yes

(If yes, please describe) ________________________________

____

____

PREGNANCY AND BIRTH HISTORY

Birth Type (circle one) Term or Preterm
Type of delivery: ☐ Vaginal ☐ C-section
Birth Weight________________
Discharge Weight______________

Newborn Hearing Screen:	☐ Pass	☐ Fail
Did baby receive HepB vaccine	☐ No	☐ Yes

Date of Hepatitis B vaccine________________________

Prenatal Care	☐ No	☐ Yes
Illnesses during pregnancy	☐ No	☐ Yes
Medication during pregnancy	☐ No	☐ Yes
Alcohol use	☐ No	☐ Yes
Drug abuse	☐ No	☐ Yes
Tobacco use	☐ No	☐ Yes
Problems at birth	☐ No	☐ Yes

____
____
____

At Delivery did Mother (Maternal) have problems with any of the following:

Diabetes	☐ No	☐ Yes
High Blood Pressure	☐ No	☐ Yes
Post-Partum Depression	☐ No	☐ Yes
STD's	☐ No	☐ Yes

Other:____
____

Did Baby have problems with any of the following:

Breathing Problems	☐ No	☐ Yes
Birth Defects	☐ No	☐ Yes
Heart Murmur	☐ No	☐ Yes
Infection	☐ No	☐ Yes
Jaundice	☐ No	☐ Yes

Other:____
____

FEEDING HISTORY

Was Baby Breast Fed or Formula?

Breast Fed	☐ No	☐ Yes
Formula Fed	☐ No	☐ Yes
Feeding Problem	☐ No	☐ Yes
Constipation	☐ No	☐ Yes
Food Allergies	☐ No	☐ Yes

PSYCHOSOCIAL HISTORY

Who lives in household:
____
____
____

(Please circle)
☐ Shelter ☐ House/Apt. ☐ Foster Care
Is child in daycare: ☐ No ☐ Yes
(If no, who is child with during the day)
____
____

Date of Birth (Biological)
Mother _____/_____/_________
Father _____/_____/_________
Parents married/divorced/separated ☐ No ☐ Yes
Parents Occupation:
Mother: ____
Father: ____
Any Family Members in Household in Jail/Prison ☐ No ☐ Yes
(If so, who)
____
____
____

Alcohol use

Mother	☐ No	☐ Yes
Father	☐ No	☐ Yes
Other Household members	☐ No	☐ Yes

(If so who)
____
____
____

Drug use

Mother	☐ No	☐ Yes
Father	☐ No	☐ Yes
Other Household members	☐ No	☐ Yes

(If so who)
____
____
____

Tobacco use

Mother	☐ No	☐ Yes
Father	☐ No	☐ Yes
Child (12 yrs +)	☐ No	☐ Yes
Other Household members	☐ No	☐ Yes

(If so who)
____
____
____

Sleep Problems ☐ No ☐ Yes
Other Languages spoken in home: _________________________
____

Provider signature: ______________________Date__________

Please explain any "Yes" answers below

____
____
____
____