MILL CREEK MEDICAL ASSOCIATES

Child and Adolescent Medical/Family History Questionnaire (Ages 0 - 17)

Patient's Name:_____
Address:_____
_____
Source of Information:_____

Today's Date:_____
Date of Birth:_____
Phone No.:_____
Emergency No.:_____
Relationship:_____

Mother's Pregnancy/Child's Birth History:

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

List # Weeks Premature or Overdue?

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?	No	Yes
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
Hospitalizations/Surgeries?	No	Yes
Physical/Emotional Abuse/Broken bones?	No	Yes

Social History:
How many living in the household?_____
Who cares for child?_____
Who lives in household?_____
_____
School?_____
Grade:_____ Any School Performance or 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 Illness?	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:
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

ALLERGIES :_____
_____
CURRENT MEDICATIONS :_____
_____
_____

Physician: _____Date:_____

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