Bethany Pediatrics, LLC
Medical/Family History Questionnaire

Patient Name:		Date of Birth:
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:_____

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?
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 ?	_____
Allergies/Asthma	No ?	Yes ?	_____
Mental Illness	No ?	Yes ?	_____
Cancer	No ?	Yes ?	_____
Birth Defects	No ?	Yes ?	_____
Hearing/Speech Problems	No ?	Yes ?	_____
Kidney Disease	No ?	Yes ?	_____
Alcohol/Drug Abuse	No ?	Yes ?	_____
Hepatitis/Liver Disease	No ?	Yes ?	_____
Thyroid Disease	No ?	Yes ?	_____
Learning Problems/Attention Deficit Disorder	No ?	Yes ?	_____
Family Violence	No ?	Yes ?	_____

Other: _____
_____

HEALTH HISTORY

Has your child ever had:

Chicken Pox (Year) ___	No ?	Yes ?
Frequent Ear Infections	No ?	Yes ?
Vision/Hearing Problems	No ?	Yes ?
Skin Problems/Eczema	No ?	Yes ?
Asthma/Allergies	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: