# CARROLL CHILDREN'S CENTER
## Medical/Family History Questionnaire

**Patient Name: ______________________________________** **Date of Birth: _________________________________**

Pregnancy and Birth History

Name of Hospital: ______________________________

Medications during pregnancy No ☐ Yes ☐

Problems at Birth? No ☐ Yes ☐

Type of delivery? ☐ Vaginal ☐ C-section

Did baby receive Hepatitis B Vaccine No ☐ Yes ☐

Newborn Hearing Screen? No ☐ Yes ☐

Illnesses during pregnancy? No ☐ Yes ☐

Alcohol/Drug Abuse? No ☐ Yes ☐

Describe: ____________________________________________________

Birth Weight _______________ Discharge Weight ______________

Date of Hepatitis B immunization: ____________________________

FAMILY HISTORY

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

| Condition | No | Yes | Who? |
|---|---|---|---|
| Allergies ___________________________ | No ☐ | Yes ☐ | ______ |
| Asthma | No ☐ | Yes ☐ | ______ |
| 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 ☐ | ______ |
| Mental Illness | No ☐ | Yes ☐ | ______ |
| Cancer | No ☐ | Yes ☐ | ______ |
| Birth Defects | No ☐ | Yes ☐ | ______ |
| Hearing Loss | No ☐ | Yes ☐ | ______ |
| Speech Problems | No ☐ | Yes ☐ | ______ |
| Kidney Disease | No ☐ | Yes ☐ | ______ |
| Alcohol/Drug Abuse | No ☐ | Yes ☐ | ______ |
| Hepatitis/Liver Disease/Thyroid Disease | No ☐ | Yes ☐ | ______ |
| Learning Problems/ADD/ADHD | No ☐ | Yes ☐ | ______ |

Other: ________________________________________________________

MEDICAL HISTORY

Has your child ever had:

| Condition | No | Yes |
|---|---|---|
| Allergies _____________________________ | No ☐ | Yes ☐ |
| Asthma | No ☐ | Yes ☐ |
| Chicken Pox (Year) ____________ | No ☐ | Yes ☐ |
| Frequent Ear Infections | No ☐ | Yes ☐ |
| Vision/Hearing Problems | No ☐ | Yes ☐ |
| Skin Problems/Eczema | 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:______________________________________________________

CURRENT MEDICATION(S): (list) ______________________________________________________________________________

Form completed by: ___________________________________________ Today's Date: ________________________________________