Child's name ______________________ Date of Birth _________

Northeast Pediatrics and Adolescent Medicine

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Past Medical, Family and Social History Questionnaire

Please give us the following information about your child's history, if known. Provide as much detail as you can. The last page of this questionnaire is blank if you need space for additional information for any item on any page.

Section I – Birth History

City of Birth______________________ Hospital _____________________________

Full term pregnancy (37 weeks or more)? ________

(If not, how many weeks premature?:__________)

List any problems which occurred during the pregnancy:
(examples: vaginal bleeding, infections, maternal diabetes, smoking, alcohol or drug exposure)

List any problems which occurred during the labor and delivery:
(examples: fever, need for forceps or vacuum assist, low fetal heart rate, breech delivery)

Check one: Vaginal ☐ or Caesarian ☐ delivery

Birth weight: Birth length: Head size:

Apgar scores at 1 minute: ________________5 minutes: __________________

Weight at discharge: Age at discharge:

List any problems which occurred after birth:
(examples: infections, need for oxygen or ventilation, jaundice, feeding difficulty, low blood sugar)

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Section II – Family and Past Medical History

In the following section, categories of medical problems are provided. Please write in details of any specific medical problems that either your child or blood relativse have had (use the blank page on the back of the questionnaire if you need more space). If you are not sure in which category a disease belongs, take your best guess or use the "Other" section at the end. Please use the abbreviations listed below, which may be combined as necessary: (for example, maternal aunt = MA; paternal great-grandfather = PGGF)

C=child
M=mother or maternal
F=father
U=uncle
S=sister
B=brother
A=aunt
G=grand or great
H=half-relation
2=second relation
P=paternal
K=cousin

Allergies

Heart problems (examples: valve problems, rhythm problems, high blood pressure, high cholesterol)

Cancer (including skin cancer such as melanoma and blood cancers such as leukemia or lymphoma)

Skin diseases (examples: eczema, problems with hair or nails, severe acne)

Dental problems (examples: gum disease, premature loss of teeth, problems with tooth appearance)

Endocrine problems (examples: thyroid disease, early/delayed puberty, menstrual problems, diabetes)

Ear/Nose/Throat problems (examples: frequent infections, malformations, hearing loss or deafness)

Eye problems (examples: lazy eye, early cataracts, glaucoma, astigmatism, color-blindness)

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Gastrointestinal problems (examples: acid reflux, colitis, constipation, food allergies, liver disease)

Genetic disorders (any condition that is inherited or "runs in the family")

Urinary problems (examples: infections, kidney or bladder malformations, bedwetting)

Blood disorders (examples: anemia, bleeding problems, blood clots, excessively heavy periods)

Immune system problems (examples: frequent infections or immune deficiency diseases)

Infectious diseases (examples: tuberculosis, sexually transmitted diseases, chicken pox, meningitis)

Neurological disorders (examples: seizures, ADD, autism, developmental problems)

Psychiatric disorders (examples: depression, bipolar, anxiety, schizophrenia, obsessive-compulsive)

Orthopedic problems (examples: bone diseases, fractures, joint problems, muscular diseases)

Respiratory problems (examples: emphysema, cystic fibrosis, frequent pneumonia, asthma)

Autoimmune disorders (examples: juvenile or adult rheumatoid arthritis, lupus)

Any other problems

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List any surgeries, hospitalizations, or injuries your child has had, with date or age and any complications:

Section III – Social History

List the name, date of birth, relation and occupation of all household members. If your child spends time in more than one household, please indicate by leaving a blank space between the members of each household.

First Name	Last Name	Relationship	Birthdate	Occupation/Employer

Home Environment:

	Household 1	Household 2
Location (Neighborhood or Town)		
Type (apartment, trailer, house, etc)		
Year built		
Is there smoking? (indicate if inside or outside)		
Pets in the home		
Weapons in the home		
Environmental hazards (examples: lead, mold, radon)		

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If your child is of school age, please indicate which school he/she attends and grade level. Describe any problems at school.

If your child is in day care, please list day care provider (including telephone number)

Please list your child's interests, including hobbies, sports, fine arts, and anything else you'd like us to know about what your child likes to do:

Please list any concerns about your child's health or any ongoing medical issues that you would like to discuss with your provider:

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Use the bottom of this page for any additional information related to any items on this questionnaire.
Please place any information that did not fit in other parts of the questionnaire on this page.