Sellwood MEDICAL CLINIC

Patient Medical History Questionnaire Today's Date:_____

Patient's Name:_____Date of Birth:_____Age Today:_____

Reason for Today's Visit:_____

**Do you have a record of this child's immunizations with you today? No/Yes**

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*Please indicate answers by filling in the blanks or by circling 'No' or 'Yes'*

If adults in the household work outside the home, what childcare arrangements are made for this child?_____

_____

Are there any cultural concerns we need to be made aware of?_____

Who lives in the home with your child?

| Name | Relation |
|---|---|
| | |
| | |
| | |
| | |
| | |

**PREGNANCY AND BIRTH**

Mother's age at birth of child?_____
Did mother have any illness during pregnancy?
_____
Did she take any medications other than vitamins and iron? No/Yes
What hospital/birth center?_____
Was the baby on time? No/Yes
Was the birth by C-section or vaginal?_____
Obstetrician/Midwife name_____
Pediatrician who saw the baby in the hospital?
_____
What was the birth weight _____Length_____
Did the baby have any trouble starting to breathe? No/Yes
Did the baby have any problems while in the hospital? No/Yes
(Jaundice, infections, other?)_____
Did the baby receive Hepatitis B vaccine in the nursery? No/Yes
Please note any other important facts:
_____
_____

**FAMILY HISTORY**

Are the child's parents both in good health? No/Yes
Circle any disease that the child's siblings, parents, grandparents, aunts, uncles or 1st cousins have: AIDS, alcohol problems, allergies, asthma, blood disorders, cancer, diabetes, drug problems, epilepsy, heart trouble, high blood pressure, high cholesterol, inherited illness, kidney disease, liver disease, lung disease, lupus, mental illness, multiple sclerosis, muscular dystrophy, SIDS, tuberculosis, venereal disease, others.
Use this space to note which relative has which disease:

Sibling-Name/Birthdate / Sex/General Health Problem(s)
_____/_____/____/_____
_____/_____/____/_____
_____/_____/____/_____
_____/_____/____/_____
Have any siblings died? No/Yes
If yes, cause of death_____

**PAST MEDICAL HISTORY**

Where has your child gone for check-ups until now?
_____
Date of last check-up:_____
Date of last dental check-up:_____
Has your child had any allergic reactions to any medications, foods, or insect bites? No/Yes
Which ones_____
Has your child had a bad reaction to any immunizations?
No/Yes Which ones_____
Any hospitalizations/surgeries other than for birth? No/Yes
For what?_____
_____
_____
Any chronic illnesses? No/Yes
If so, please list_____
Any serious injuries, broken bones, stitches? No/Yes
What kind?_____
Are any medications taken regularly? No/Yes
Which ones?_____
Has your child has/had any of the following: (circle)
Rubella(German Measles), Pertussis (Whooping Cough), Strep Throat, Chicken Pox, Diptheria, Scarlet Fever, Tonsillitis, Heart Murmur, Diabetes?

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**REVIEW OF SYSTEMS**

Has your child had frequent ear infections? No/Yes
Any hearing problems? No/Yes
Any vision problems? No/Yes
Has he/she had any problems with teeth? No/Yes
Does this child have frequent colds or sore throat? No/Yes
Does he/she have a history of allergies, asthma
Pneumonia, bronchitis or recurrent cough? No/Yes
(circle any which are yes)
Any problems with kidneys, bladder or urination? No/Yes
Have there been any convulsions or any other
problems with the nervous system? No/Yes
Any problems with diarrhea or constipation? No/Yes
Any eczema, hives or other skin conditions? No/Yes
Has your child ever been anemic? No/Yes
Has your child ever seen a specialist? No/Yes
If so, for what?_____
Please note any other important facts:
_____

**SAFETY/ENVIRONMENT**

Do you live in a private house, mobile home,
apartment, condo, other?_____
Who currently lives in the household?
_____
Do you know the hottest temperature of the water in your
pipes? No/Yes
Is there a working smoke alarm for each floor of your house?
No/Yes
Is there a working fire extinguisher in your home? No/Yes
Does the child always use a car seat/seat belt while in the car?
No/Yes
Are there any smokers in the home? No/Yes
Are there any problems with the condition of your home?
(Peeling paint, insects, rats or mice?) No/Yes
Does your child always wear a helmet when riding a
bicycle/skateboard or other like activities? No/Yes
Are there pets in your home? No/Yes
If yes, how many and what types?_____
_____
Are there guns in the home? No/Yes
Is there a swimming pool or hot tub? No/Yes

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**FEEDING AND NUTRITION**

Current nutrition: breast fed, formula fed, table food (circle)
For the first 6 moths was this child breast fed or formula fed:
(circle) If formula fed, which one?_____
Amount _____oz per _____
If on regular milk, which? Whole, 2% 1%, non fat? (circle)
Amount of milk per day? _____
Is your child's appetite usually good? No/Yes
Is it good now? No/Yes
Was there severe colic or any other unusual feeding problems
during the first three months? No/Yes
Do any foods disagree with him/her? No/Yes
If so, which ones?_____
Does he/she take vitamins/fluoride? No/Yes
Which ones?_____

**DEVELOPMENT/BEHAVIOR**

***(Answer if child is less than 5 years –ONLY)***

At what age did this child sit alone?_____
At what age did he/she walk alone?_____
Did he/she say any words by 15 months of age? No/Yes
How does this child compare to others of his/her age?
Same, Advanced, Behind (circle one)
Are there any problems with sleeping? No/Yes

***(Answer if child is more than 5 years—Only)***

What grade is the child? _____
Has he/she had any trouble with school? No/Yes
Does she/he get alone well with other children? No/Yes
If your child has had any of the following, please circle:
Nail biting, thumb sucking, bed wetting, bad temper, problems
with toilet training, hyperactivity, nightmares, speech
problems, problems with discipline,
others:_____
_____