



Medical History Questionnaire

DATE _____ FORM COMPLETED BY _____ RELATION TO CHILD _____

PATIENT INFORMATION

CHILD'S NAME _____
(First) (Middle) (Last)

DATE OF BIRTH _____ AGE _____ SEX M / F

CURRENT MEDICATIONS _____

ALLERGIES _____

CONCERNS AND GOALS

WHAT ARE YOUR MAIN CONCERNS FOR YOUR CHILD? _____

WHAT WOULD YOU LIKE TO SEE YOUR CHILD ACHIEVE? _____

WHAT ARE YOUR GOALS? _____

SOCIAL HISTORY

GUARDIAN 1 _____ GUARDIAN 2 _____

PARENTS ARE CURRENTLY (circle one): Married / Separated / Divorced

CHILD LIVES WITH _____

SOCIAL HISTORY (CONTINUED)

IS CHILD ADOPTED? Y / N IF YES, WHEN? _____ IN FOSTER CARE? Y / N IF YES, HOW LONG? _____

PARENTS WORK OUTSIDE OF HOME? GUARDIAN 1 _____ GUARDIAN 2 _____

CHILD IS: AT HOME WITH CARE PROVIDER: _____ AT DAYCARE: _____
(where, hours/days)

AT SCHOOL _____
(where) (grade) (teacher name)

MEDICAL HISTORY

FORMAL DIAGNOSIS? _____

WHEN WAS YOUR CHILD DIAGNOSED AND BY WHOM?

WHO IS YOUR CHILD'S PRIMARY CARE PROVIDER? _____

DOES YOUR CHILD RECEIVE MEDICAL CARE FROM OTHER SPECIALITY PROVIDERS? Y / N

PLEASE LIST: _____

ANY OTHER AGENCIES FOR THERAPY SERVICES? Y / N IF YES, _____

MOTHER'S PREGNANCY:

INFECTIONS/ILLNESS/INJURIES? Y / N Please explain _____

MEDICATIONS DURING PREGNANCY? Y / N Please explain _____

DRUG/ALCOHOL/TOBACOCO USE? Y / N Please explain _____

UNUSUAL STRESS? Y / N Please explain _____

LABOR AND DELIVERY:

NATURAL ONSET OF LABOR OR INDUCED? (circle one)

VAGINAL OR C-SECTION? (circle one) DELIVERY ASSISTED WITH FORCEPS OR VACUUM EXTRACTION? (circle one)

ANY COMPLICATIONS DURING DELIVERY? _____

MEDICAL HISTORY (CONTINUED)

CHILD'S BIRTH HISTORY:

BIRTH WEIGHT: _____

BORN PREMATURE? Y / N IF SO, HOW MANY WEEKS?

ADMITTED TO NICU? Y / N IF SO, WHY AND OR HOW LONG? _____

AT BIRTH OR AS A NEWBORN, DID YOUR CHILD HAVE:

BREATHING PROBLEMS OR NEED BREATHING SUPPORT? Y / N IF SO, PLEASE EXPLAIN: _____

HEART PROBLEMS? Y / N IF SO, PLEASE EXPLAIN: _____

BIRTH INJURIES OR ABNORMALITIES? Y / N IF SO, PLEASE EXPLAIN:

SEIZURES? Y / N _____

INFECTIONS? Y / N _____

PASS NEWBORN HEARING SCREEN? Y / N

CHILD'S MEDICAL HISTORY:

HOSPITALIZATIONS? Y / N IF SO, PLEASE EXPLAIN: _____

SURGERIES? Y / N IF SO, PLEASE EXPLAIN: _____

SHUNT? Y / N PLEASE DESCRIBE _____

ISSUES WITH THE FOLLOWING?

	PAST	CURRENT	PLEASE DESCRIBE
EAR INFECTIONS			
SKIN ISSUES (ECZEMA, HIVES, CRADLE CAP, OTHER)			
DIARRHEA			
CONSTIPATION			
STOMACHE PAINS			
VOMITTING			
REFLUX			

VISION EXAM? Y / N IF YES, BY WHOM? _____ WHEN? _____

HEARING EXAM? Y / N IF YES, ANY CONCERNS? _____

FEEDING HISTORY

BREAST FED? Y / N IF YES, HOW LONG? _____

BOTTLE FED? Y / N IF YES, HOW LONG? _____

SWITCH FORMULAS? Y / N PLEASE EXPLAIN _____

FREQUENT SPIT UPS OR VOMITTING? Y / N PLEASE EXPLAIN: _____

REFLUX? Y / N IF YES, DID IT REQUIRE TREATMENT? Y / N _____

PROBLEMS GAINING WEIGHT? Y / N _____

DIFFICULTIES TRANSITIONING OFF BOTTLE OR TO FOOD? Y / N _____

HISTORY OF FEEDING DIFFICULTIES? Y / N PLEASE EXPLAIN:

DEVELOPMENTAL HISTORY

PLEASE PROVIDE INFORMATION ON WHEN YOUR CHILD:

ROLLED OVER _____ SAT INDEPENDENTLY _____

CRAWLED _____ WALKED _____

SPOKE FIRST WORD _____ SPOKE FIRST SENTENCE _____

TOILET TRAINED (DAY) _____ (NIGHT) _____