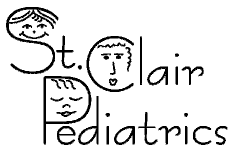

Medical History Questionnaire

Greg T. Garrison, M.D
Jill A. Johnston, M.D
Kevin M. Ponciroli, M.D.
Ginny Minnigerode, C.P.N.P.

Patient Name: ______________________________ **Date of Birth**: ____________
Last First MI (MM/DD/YYYY)

Is the patient adopted? ☐ Yes ☐ No If yes, in what country was the patient born? ____________

Allergies to medication, food or environment: ____________

Pre-existing medical conditions: ☐ Asthma ☐ Heart Disease ☐ Allergies ☐ Eczema ☐ Diabetes ☐ Autism ☐ ADHD
Other: ____________

Current medications (and dosages): ____________

List any hospitalizations or surgeries: ____________

Check any that occurred during the pregnancy with this child:

☐ Group B Strep ☐ Hospitalizations ☐ Tobacco/Alcohol/Drug Abuse ☐ Chronic Nausea
☐ High Blood Pressure ☐ X-rays ☐ Bleeding/Spotting ☐ Excessive Weight Loss
☐ Gestational Diabetes ☐ Rubella ☐ Infections ☐ Fetal Movement Problems
☐ RH Factor Incompatibility ☐ Accidents or Falls ☐ Amniocentesis ☐ Prescribed Medications

Other: ____________

Birth History ☐ Term (>37 weeks) ☐ Born Premature @ ____ weeks ☐ Single ☐ Multiple Birth
Mother's age at child's birth: ________ Father's age: ________ Birth Weight: ________ Birth Length: ________
Hospital: ____________ Labor: ☐ Induced ☐ Spontaneous Delivery: ☐ Vaginal ☐ Cesarean ☐ Breech (feet first)
Apgar Scores: ______ Complications: ____________

Infancy Check any that occurred: ☐ Jaundice ☐ Dehydration ☐ Chronic Diarrhea ☐ Failure to Thrive
☐ Allergies ☐ Colic ☐ Vomiting ☐ Feeding Problems

Growth and Development Did growth occur at a normal rate? ☐ Yes ☐ No
Indicate in what month the milestone was reached:
Walked unsupported: ________ Spoke words: ________ Spoke sentences: ________ Toilet trained: ________
Describe any current growth or fine/gross motor difficulties: ____________

Social Factors Who lives with this child? ____________
Mother's Occupation: ____________ Father's Occupation: ____________
Does anyone living with this child smoke? ☐ Yes ☐ No Pets in home? ☐ Yes ☐ No What kind? ____________
Where does this child live? ☐ Home ☐ Apartment ☐ Other How old is this residence? ____________
Do parents work with (check all that apply): ☐ Metal ☐ Chemicals ☐ Ceramics ☐ Lead ☐ Paint Stripping
Check type of heat source in the home: ☐ Electric ☐ Gas ☐ Oil ☐ Kerosene ☐ Wood Stove

Family Medical History Check if child's natural parents, siblings, aunts, uncles or grandparents have had any of the following:

☐ High Blood Pressure ☐ Allergies ☐ Emotional Problems ☐ Mental Retardation / Autism ☐ GI / Kidney / Liver diseases
☐ High Cholesterol ☐ Eczema ☐ Sight / Hearing Problems ☐ Alcohol / Drug Addiction ☐ Sickle Cell Anemia
☐ Early Heart Attack / Stroke (before age 55) ☐ Asthma ☐ Diabetes ☐ Hyperactivity / ADHD ☐ Hemophilia
☐ Cancer ☐ Epilepsy / Seizures ☐ Headaches ☐ None of the above