## Maryland Healthy Kids Program Medical/Family History Questionnaire

Patient Name:			Date of Birth:	of Birth: Sex: (circle) Male Female			
Form Completed By:	Today	y's Date	Relationship:				
PREGNANCY AND BIRTH HISTORY			PSYCHOSOCIAL HISTORY				
Name of Hospital: Illnesses during pregnancy? No ☐ Yes ☐			Who lives in household?				
Medications during pregnancy? No ☐ Yes ☐ Alcohol/Drug Abuse? No ☐ Yes ☐ Problems at birth? No ☐ Yes ☐ Describe: ☐ Type of delivery? ☐ Vaginal ☐ C-section			How many?  Rent? Own? Shelter?  Who cares for child?  Date of Birth? Mother  Father				
Birth Weight Disc Did baby receive Hepatitis B vac	Are parents working? Mother No ☐ Yes ☐ Father No ☐ Yes ☐						
Date of Hepatitis B immunization:			Foster Care?Dates:				
Newborn Hearing Screen? No □ Yes □			Other Languages?				
FAMILY HISTORY			MEDICAL HISTORY				
Has anyone in the family (parents, grand-parents,			Has your child ever had:				
aunts/uncles, sisters/brothers) h		Who?	Allergies (List)	No		Yes □	
Allergies (List)	No □	Yes □	Asthma	No		Yes □	
Asthma	No □	Yes □	Chicken Pox (Year)			Yes □	
	No 🗆	Yes □	Frequent Ear Infections			Yes □	
_	No 🗆	Yes □	Vision/Hearing Problems			Yes □	
	No 🗆	Yes □	Skin Problems/Eczema			Yes □	
-	No □	Yes □	TB/Lung Disease			Yes □	
High Blood Pressure/Stroke	No □	Yes □	Seizures/Epilepsy	No		Yes □	
_	No □	Yes □	High Blood Pressure	No		Yes □	
	No □	Yes □	Heart Defects/Disease	No		Yes □	
Diabetes I	No □	Yes □	Liver Disease/Hepatitis	No		Yes □	
Seizures	No □	Yes □	Diabetes	No		Yes □	
Mental Illness	No □	Yes □	Kidney Disease/Bladder Infection	ns No		Yes □	
Cancer	No □	Yes □	Physical or Learning Disabilities	No		Yes □	
Birth Defects	No □	Yes □	Bleeding Disorders/Hemophilia	No		Yes □	
II — — — — — — — — — — — — — — — — — —	No □	Yes □	Sexually Transmitted Diseases			Yes □	
•	No □	Yes	Emotional or Behavioral Problem	ns No		Yes □	
	No 🗆	Yes □	Depression/Suicidal Thoughts			Yes □	
	No 🗆	Yes □	Hospitalizations/Surgeries			Yes □	
Hepatitis/Liver Disease	_		Physical/Emotional/ Sexual Abus			Yes □	
	No 🗆	Yes □	Bone or Joint Injuries			Yes □	
	No 🗆	Yes □	Obesity/Eating Disorders			Yes □	
	No 🗆	Yes □	Other:	_ No		Yes □	
Family Violence	No □	Yes □		_			
Other:			Current Medication(s): ( <i>List</i> )				
Poviowed by			Date of Basiless				
Reviewed by:			Date of Review:				