KENSINGTON – GAITHERSBURG

Medical/Family History Questionnaire

Patient Name:	Date of Birth:	Sex: (circle) Male Female
Form Completed By: / Today's Date:	Relationship:	

PREGNANCY AND BIRTH HISTORY

Name Of Hospital: _____

Illnesses during pregnancy? No ☐ Yes ☐

Medications during pregnancy? No ☐ Yes ☐

Alcohol/Drug Abuse? No ☐ Yes ☐

Problems at birth? No ☐ Yes ☐

Describe: _____

Type of Delivery? ☐ Vaginal ☐ C-Section

Birth weight: _____ Discharge Weight: _____

Did baby receive Hepatitis B vaccine? No ☐ Yes ☐

Date of Hepatitis B immunization: _____

Newborn Hearing Screen? No ☐ Yes ☐

PSYCHOSOCIAL HISTORY

Who lives in household? _____

_____

How many? _____

☐ Rent? ☐ Own? ☐ Shelter?

Who cares for child? _____

Date of Birth? Mother: _____

Father: _____

Are parents working? Mother: No ☐ Yes ☐

Father: No ☐ Yes ☐

Foster Care? _____ Dates: _____

Other languages? _____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers had:

			Who?
Allergies (List) _____			
_____			
Asthma	No ☐	Yes ☐	_____
TB/Lung Disease	No ☐	Yes ☐	_____
HIV/AIDS	No ☐	Yes ☐	_____
Suicide Attempts	No ☐	Yes ☐	_____
Heart Disease	No ☐	Yes ☐	_____
High Blood Pressure/Stroke	No ☐	Yes ☐	_____
High Cholesterol	No ☐	Yes ☐	_____
Blood Disorders/Sickle Cell	No ☐	Yes ☐	_____
Diabetes	No ☐	Yes ☐	_____
Seizures	No ☐	Yes ☐	_____
Mental Illness	No ☐	Yes ☐	_____
Cancer	No ☐	Yes ☐	_____
Birth Defects	No ☐	Yes ☐	_____
Hearing Loss	No ☐	Yes ☐	_____
Speech Problems	No ☐	Yes ☐	_____
Kidney Disease	No ☐	Yes ☐	_____
Alcohol/Drug Abuse	No ☐	Yes ☐	_____
Hepatitis/Liver Disease	No ☐	Yes ☐	_____
Thyroid Disease	No ☐	Yes ☐	_____
Learning Problems/Attention Deficit Disorder	No ☐	Yes ☐	_____
Family Violence	No ☐	Yes ☐	_____

Other: _____

_____

Reviewed By: _____

MEDICAL HISTORY

Has your child ever had:

Allergies (List) _____	No ☐	Yes ☐
_____		
Asthma	No ☐	Yes ☐
Chicken Pox? Year: _____	No ☐	Yes ☐
Frequent Ear Infections	No ☐	Yes ☐
Vision/Hearing Problems	No ☐	Yes ☐
Skin Problems/Eczema	No ☐	Yes ☐
TB/Lung Disease	No ☐	Yes ☐
Seizures/Epilepsy	No ☐	Yes ☐
High Blood Pressure	No ☐	Yes ☐
Heart Defects/Disease	No ☐	Yes ☐
Liver Disease/Hepatitis	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐
Kidney Disease/Bladder Infections	No ☐	Yes ☐
Physical or Learning Disabilities	No ☐	Yes ☐
Bleeding Disorders/Hemophilia	No ☐	Yes ☐
Sexually Transmitted Diseases	No ☐	Yes ☐
Emotional or Behavioral Problems	No ☐	Yes ☐
Depression/Suicidal Thoughts	No ☐	Yes ☐
Hospitalizations/Surgeries	No ☐	Yes ☐
Physical/Emotional/Sexual Abuse	No ☐	Yes ☐
Bone or Joint Injuries	No ☐	Yes ☐
Obesity/Eating Disorders	No ☐	Yes ☐
Other: _____	No ☐	Yes ☐

_____

Current Medication(s): (List) _____

_____

Date of Review: _____