KENSINGTON – GAITHERSBURG

Medical/Family History Questionnaire

Patient Name:		Date of Birth:	Sex:
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, grandparents, aunts/uncles, sisters/brothers) had:

	Yes/No		Who?
Allergies (List) __________	No ☐	Yes ☐	__________
__________			
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	No ☐	Yes ☐	__________
Deficit disorder	No ☐	Yes ☐	__________
Family violence	No ☐	Yes ☐	__________

Other: ____________________

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 ☐
Hepatitis/liver disease	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: ____________________

Current medication(s): ____________________

Reviewed by:	Date of review: