

HEALTHY KIDS PROGRAM  
**Medical/Family History Questionnaire**

Practice Name: \_\_\_\_\_ Date of Entry: \_\_\_\_\_  
 Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_  
 \_\_\_\_\_ Emergency No.: \_\_\_\_\_  
 Source of Information: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Mother's Pregnancy/Child's Birth History: (under 2 years old)**

Illnesses during pregnancy? No Yes  
 Any 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: \_\_\_\_\_  
 Name of Hospital: \_\_\_\_\_  
 Was first PKU done? No Yes

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**Patient's Health History: Has your child every had...**

Measles/Mumps/Chicken Pox? No Yes  
 Frequent ear infections? No Yes  
 Vision/Hearing Problems? No Yes  
 Skin Problems? No Yes  
 Asthma/Allergies? No Yes  
 TB/Lung disease/Croup? 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  
 Handicaps/Disabilities? No Yes  
 Bleeding Disorders/Hemophilia? No Yes  
 Sexually Transmitted Diseases? No Yes  
 Emotional Problems/Suicide Attempts? No Yes  
 Hospitalizations/Surgeries? No Yes  
 Physical/Emotional Abuse/Broken bones? No Yes  
 Immunizations Up-to-date? No Yes

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**Psycho-Social History:**

How many living in the household? \_\_\_\_\_  
 Who cares for child? \_\_\_\_\_  
 Are parents working? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Name of School? \_\_\_\_\_  
 Grade: \_\_\_\_\_  
 Behavior problems? \_\_\_\_\_

Comments: \_\_\_\_\_

**Family History:** Has anyone in the family (parents, grand-  
 parents, aunts/uncles, sisters/brothers, cousins, etc.) had the following:

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

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**Adolescent History: (interview separately)**

Age at first period \_\_\_\_\_ LMP \_\_\_\_\_  
 Sexually Active? No Yes # of partners? \_\_\_\_\_  
 Sex of partners? M/F  
 Any fears of partner/other violence? No Yes  
 Smoker? No Yes Alcohol Use? No Yes  
 Drug Use? No Yes Working? No Yes  
 Do you think about hurting yourself? No Yes  
 Access to gun/weapon? No Yes

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Provider: \_\_\_\_\_

Date: \_\_\_\_\_

Updates: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Heart Disease/Cholesterol Risk Assessment:**

(2 years through 20 years)

1. Is there a family history of parents/grandparents under the age 55 years with heart attack/surgery stroke, high blood pressure, high cholesterol, sudden death, or diabetes?
2. Is there personal history of:  
Smoking?  
  
Lack of physical activity?  
  
High blood pressure?  
  
High cholesterol?  
  
Obesity/overweight?

**STD/HIV Risk Assessment:**

(11 through 20 years)

1. Have you had a blood transfusion or are you currently diagnosed with Hemophilia?
2. Have you ever been sexually molested or physically attacked?
3. Have you ever been diagnosed with any sexually transmitted diseases (gonorrhea, syphilis, venereal warts, chlamydia, herpes)?
4. Any history of IV drug use by you, your sex partner, or your birth mother during pregnancy?
5. If sexually active, have you had unprotected sex, with opposite/same sex (circle appropriate response)?
6. If sexually active, have you had more than one sex partner?
7. Any body tattoos or piercing of ears, navel, etc., including any performed by friends?

**Tuberculosis Risk Assessment:**

(Initial visit and yearly thereafter)

1. Was your child born in, or lived more than a year in a country other than the U.S?  
Where? \_\_\_\_\_ Year? \_\_\_\_\_
2. Has your child been exposed to anyone with either active tuberculosis or a history of tuberculosis disease?
3. Is your child currently living in a household with anyone who is HIV positive?
4. Is your child part of a migrant worker family?

**Lead Risk Assessment:**

(6 months to 6 years)

1. Does your child currently live, or has he/she ever lived in a house or apartment built before 1960 (includes day care center, preschool home, home of babysitter or relative)?
2. Is anyone in the home being treated or followed for lead poisoning?
3. Are there any current renovations or peeling paint in a home that your child regularly visits?
4. Is there any family member who is currently working in an occupations or hobby where lead exposure could occur? (auto mechanic, ceramics, commercial painter, etc.)