Medical Questionnaire
Ages 0 - 12

Child's Name ____ Date of Birth ______________
Questionnaire filled out by ____
Relationship to child ____
Date of visit ____

Prenatal/Neonatal History (please fill out if your child is less than 3 years old):

1. How many months were you pregnant with your child? ___________________________
2. How many weeks/months were you into the pregnancy when you made your first visit to the doctor? _____
3. Any problems during your pregnancy? ☐ No ☐ Yes
   If yes, please list ____
4. What type of delivery? ☐ Vaginal ☐ Cesarean
5. Any problems during the delivery? ☐ No ☐ Yes
   If yes, please list ____
6. Birth Weight _______________ Birth Length ___________________
7. Any problems at the hospital nursery? ☐ No ☐ Yes
   If yes, please list ____

Medical History:

1. Has your child been diagnosed with any of these illnesses or medical conditions? (check all that apply)
   - ☐ Anemia
   - ☐ Asthma
   - ☐ Attention Deficit Disorder w/Hyperactivity (ADHD)
   - ☐ Chronic diarrhea
   - ☐ Chronic ear infections
   - ☐ Diabetes
   - ☐ Head injury
   - ☐ Heart murmur
   - ☐ Nasal allergies/sinusitis
   - ☐ Reflux
   - ☐ Seizures
   - ☐ Urine/bladder infection
   - ☐ Other specify____

   ☐ **My child does not have any of these illnesses.**

2. Has your child ever been admitted to a hospital? ☐ No ☐ Yes
   If yes
   a. What was the admission for? ____
   b. How old was your child? ____
   c. Name of hospital and city ____

3. Has your child ever had any surgeries? ☐ No ☐ Yes
   If yes
   a. What was the surgery for? ____
   b. How old was your child? ____
   c. Name of hospital and city ____

4. Does your child have any allergies to food or medications? ☐ No ☐ Yes
   If yes, please list ____

5. Are your child's immunizations up to date? ☐ No ☐ Yes
   If no, which are pending? ____

6. Please check all that apply to your child's health at this time
   ☐ Loss of energy
   ☐ Weight loss
   ☐ Weight gain
   ☐ Trouble with eyesight
   ☐ Wears glasses
   ☐ Difficulty hearing
   ☐ Teeth are discolored and break easily
   ☐ Gums bleed easily
   ☐ Bleeds for a long time after a cut
   ☐ Wheezing
   ☐ Muscle aches
   ☐ Joint pain or swelling
   ☐ Hives
   ☐ Eczema

   ☐ **My child does not have any of these problems.**

7. Is your child taking any medications or vitamins now? ☐ No ☐ Yes
   If yes, what is he/she taking? ____
   ____

   What illness/condition is he/she taking this for? _______________________________________
   ____

8. Who is your child's doctor? ____
   In what town/city does the doctor have his/her practice? ________________________________

Family Medical History

Do any of your child's siblings, parents or grandparents suffer any of the following medical conditions? (Check all that apply and identify the family member affected by each illness)

☐ Anemia ____
☐ Asthma ____
☐ Delay in talking, moving around or understanding things ___________________________
____
☐ Diabetes ____
☐ Drug/alcohol addiction ____

Child's Name ______________________________ Date of Birth ______________

- ☐ Had a lot of broken bones ______________________
- ☐ Had a lot of discolored, broken or chipped teeth ______________________
- ☐ Heart disease ______________________
- ☐ HIV/AIDS ______________________
- ☐ Loss of hearing______________________
- ☐ Mental retardation ______________________
- ☐ Nasal allergies ______________________
- ☐ Nosebleeds; bruises easily ______________________
- ☐ Psychiatric or mental illness ______________________
- ☐ Seizures ______________________
- ☐ Does anyone in your household smoke? ______________________
- ☐ Other (please list) ______________________

☐ **No one in my family has any of these illnesses or problems**

Developmental History (please fill out if your child is less than 3 years old):

1. At what age did your child do the following for the first time?
   a. Roll over ______________________
   b. Sit up on his/her own ______________________
   c. Stand up ______________________
   d. Walk ______________________
   e. Run ______________________
   f. Clear words ______________________
2. Is your child already talking in phrases or sentences? ☐ No ☐ Yes
3. Is your child already toilet-trained? ☐ No ☐ Yes
4. What do you do when your child is acting up? ______________________

____

____

Daycare/School Attendance

1. Does your child have a babysitter? ☐ No ☐ Yes
   If yes, give name and location _______
   Which days and what hours does your child spend with the babysitter? ______________

   ____
2. Does your child attend a daycare center? ☐ No ☐ Yes
   If yes, give name and location ______________________
3. Does your child go to school? ☐ No ☐ Yes
   If yes, give the name and location______________________
4. Which grade is your child in? ______________________
5. How is your child doing in school?
   ☐ Excellent ☐ Good ☐ Average ☐ Failing
6. If your child is failing at school, what is the problem? ______________________

   ____

   ____

   ____

   ____

   ____
7. Does your child attend an after-school program? ☐ No ☐ Yes
   If yes, give name and location ______________________

   ____

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Social History

1. Please list all adults and children currently living in same home as your child and their relationship to your child: ____
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____
____
____
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____
____
____
____

2. Has your family had any previous involvement with DSS? ☐ No ☐ Yes
If yes, please list the year and reason for involvement: ______________________________
____
____
____
____
____
____
____
____
____
____

3. Has your child ever been around domestic violence? ☐ No ☐ Yes

Additional Comments by Healthcare Provider:

Questionnaire reviewed by: ________________________________ Review Date _______________
Healthcare Provider