2010 South Arlington Heights Rd. Suite 210 Arlington Heights, IL 60056

Summers Pediatrics S.C. (847) 758-2080

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| --- |
| **Medical/Family History Questionnaire** |
| Patient Name:  |  |  | Date of Birth:  |  |  |
| Today's Date:  |  |  | Form Completed By:  |  |  |
|  |  |  |  |  |  |
| **PREGNANCY & BIRTH HISTORY** |  **CHILD MEDICAL HISTORY** |
|  |  |  | Hospitalizations When?  |  |  |
| Mother’s Blood Type? Baby’s Blood Type?Illnesses during pregnancy? |  |   Explain:No Yes  |  Reason Serious Injury: |  |  |  |
| Medications during pregnancy? | No Yes  |  When?  |
| Alcohol/Drug Abuse? |  | No Yes  |  Reason  |  |
| Problems at birth? |  | No Yes  |  |  |  |
| Describe:  |  |   | Surgery |  |  |  |
| Premature? No YesProblems During Delivery? | How early?   |  When?  What Kind  |  |  |  |
| Type of Delivery? | Vag C-Sect  | Allergies(list):  |  |  |  | : |  |  |
| Did baby receive Hep B vaccine? | No Yes |   |  |  |  |
| Date of Hep B shot? |  |   | Reaction: |  |  |
| Newborn Hearing Screen?Newborn Testing? |  | No YesNo Yes |   |  |  |  |
|  | **FAMILY HISTORY** | **Current Medications:**  |  |
| Allergies:  |  |  |  |
|  |   |  |
| **Has anyone in the family (parents, grandparents, aunts/uncles, sisters/brothers) had:** | **Has your child ever had:** |
|  |  | Describe | Asthma |  | No Yes |
| Asthma | No Yes |   | Chicken Pox (year) |  | No Yes |
| Lung DiseaseTuberculosis | No YesNo Yes |    | Frequent Ear Infections (4times a year or more) |  | No Yes |
| HIV/AIDSSuicide Attempts | No YesNo Yes |    | Wheezing Problems Bronchitis | No YesNo Yes |
| Heart Disease | No Yes |   | Pneumonia |  | No Yes |
| High Blood Pressure/Stroke | No Yes |   | TB/Lung Disease |  | No Yes |
| High Cholesterol | No Yes |   | Seizures/Epilepsy |  | No Yes |
| Blood Disorders/Sickle Cell | No Yes |   | High Blood Pressure |  | No Yes |
| Seizures | No Yes |   | Heart Defects/Disease  |  | No Yes |
| Diabetes | No Yes |   | Liver Disease/Hepatitis |  | No Yes |
| Family Violence | No Yes |   | Diabetes |  | No Yes |
| Mental Illness | No Yes |   | Kidney Disease/Bladder Infections | No Yes |
| CancerEye DiseaseBone or Joint DiseaseAlcohol/Drug Abuse | No YesNo YesNo YesNo Yes |      | Strep Throat (3 times a year or more)Learning DisabilitiesAnemia |  | No YesNo YesNo Yes |
| Birth Defects | No Yes |   | Bleeding Disorders/Hemophilia | No Yes |
| Hearing Loss | No Yes |   | Sexually Transmitted Diseases | No Yes |
| Speech Problems | No Yes |   | Emotional/Behavioral Diseases | No Yes |
| Kidney Disease | No Yes |   | Depression/Suicidal Thoughts | No Yes |
| Hepatitis/Liver Disease | No Yes |   | Hospitalizations/Surgeries | No Yes |
| Gastrointestinal DiseaseCrohn’s Disease Ulcerative Colitis  | No YesNo YesNo Yes |     | AbuseSexual/Physical/Emotional Bone or Joint InjuriesVision/Hearing Problems | No YesNo YesNo Yes |
| Thyroid DiseaseMuscle DiseasePsychiatric DiseaseSkin Disease | No YesNo YesNo YesNo Yes |      | Skin Problems/EczemaObesity/Eating Disorders |  | No YesNo Yes |
| Learning Problems/ADD | No Yes |   | Other:  |  |
|  |  |   |  |  |  |  |
| Other:  |  |  |   |  |  |
|  |  |  |  |  |  |