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

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

(847) 758-2084

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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 Yes  Problems 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 Disease  Tuberculosis | | | | No Yes  No Yes | | |  | | | | Frequent Ear Infections (4times a year or more) | | | | |  | | No Yes | | | | | | | | | |
| HIV/AIDS  Suicide 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 | | | | | | | | | |
| Cancer  Eye Disease  Bone or Joint Disease  Alcohol/Drug Abuse | | | | No Yes  No Yes  No Yes  No Yes | | |  | | | | Strep Throat (3 times a year or more)  Learning Disabilities  Anemia | | | | | | |  | 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 Disease  Crohn’s Disease  Ulcerative Colitis | | | | No Yes  No Yes  No Yes | | |  | | | | AbuseSexual/Physical/Emotional  Bone or Joint Injuries  Vision/Hearing Problems | | | | | | | No Yes  No Yes  No Yes | | | | | | | | | |
| Thyroid Disease  Muscle Disease  Psychiatric Disease  Skin Disease | | | | No Yes  No Yes  No Yes  No Yes | | |  | | | | Skin Problems/Eczema  Obesity/Eating Disorders | | | | | | |  | No Yes  No Yes | | | | | | | | | | | |
| Learning Problems/ADD | | | | No Yes | | |  | | | | Other: | | | | | | | | | | | | | | | |  |
|  | | | |  | | |  | | | |  | |  | | | |  | | |  | | | | | | | | | |
| Other: | | | | | |  |  | | | |  | | | | | | | | | | | | | | |  |  |
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