Maryland Healthy Kids Program Medical/Family History Questionnaire

Patient Name:			Date of Birth:	Sex: (circle) Male Female		
Form Completed By:	Today	's Date	Relationship:			
PREGNANCY AND BIRTH HISTORY			PSYCHOSOCIAL 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:			Who lives in household? How many? Rent?			
Newborn Hearing Screen? No ☐ Yes ☐			Other Languages?			
FAMILY HISTORY			MEDICAL HISTORY			
Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had: Who?			Has your child ever had: Allergies (List)	No 🗆	Voc. 🗆	
Allergies (List)	No □		Asthma	_ No 🗆	Yes □	
TB/Lung Disease HIV/AIDS Suicide Attempts Heart Disease High Blood Pressure/Stroke High Cholesterol Blood Disorders/Sickle Cell Diabetes Seizures Mental Illness Cancer Birth Defects Hearing Loss Speech Problems Kidney Disease Alcohol/Drug Abuse Hepatitis/Liver Disease Thyroid Disease Learning Problems/Attention Deficit Disorder	No	Yes	Chicken Pox (Year) Frequent Ear Infections Vision/Hearing Problems Skin Problems/Eczema TB/Lung Disease Seizures/Epilepsy High Blood Pressure Heart Defects/Disease Liver Disease/Hepatitis Diabetes Kidney Disease/Bladder Infection Physical or Learning Disabilities Bleeding Disorders/Hemophilia Sexually Transmitted Diseases Emotional or Behavioral Problem Depression/Suicidal Thoughts Hospitalizations/Surgeries Physical/Emotional/ Sexual Abus Bone or Joint Injuries Obesity/Eating Disorders Other:	No	Yes Yes	
Other:			Current Medication(s): (<i>List</i>)			
Reviewed by:			Date of Review:			