Name
DOB
Date

Garrett Medical Group, P.A.

MARYLAND HEALTHY KIDS PROGRAM

Medical/Family History Questionnaire

Practice Name: Garrett Medical Group, P.A.
Patient's Name: ____
Address: ____
Source of Information: ____

Date of Entry: ____
Date of Birth: ____
Phone No.: ____
Emergency No.: ____
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 clone?	No	Yes

Patient's Health History: Has your child ever 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

Psycho-Social History:

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

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

			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	

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 thin about hurting yourself? No Yes
Access to gun/weapon? No Yes

Provider: ____
Date: ____

Comments: ____

Updates: / / / / / / /