

Maryland Healthy Kids Program Medical/Family History Questionnaire

Patient Name: _____		Date of Birth: _____	Sex: (circle) Male <input type="checkbox"/> Female <input type="checkbox"/>																																																																																																																																																																								
Form Completed By: _____	Today's Date: _____	Relationship: _____																																																																																																																																																																									
PREGNANCY AND BIRTH HISTORY		PSYCHOSOCIAL HISTORY																																																																																																																																																																									
Name of Hospital: _____ Illnesses during pregnancy? No <input type="checkbox"/> Yes <input type="checkbox"/> Medications during pregnancy? No <input type="checkbox"/> Yes <input type="checkbox"/> Alcohol/Drug Abuse? No <input type="checkbox"/> Yes <input type="checkbox"/> Problems at birth? No <input type="checkbox"/> Yes <input type="checkbox"/> Describe: _____ Type of delivery? <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section Birth Weight _____ Discharge Weight _____ Did baby receive Hepatitis B vaccine? No <input type="checkbox"/> Yes <input type="checkbox"/> Date of Hepatitis B immunization: _____ Newborn Hearing Screen? No <input type="checkbox"/> Yes <input type="checkbox"/>		Who lives in household? _____ How many? _____ <input type="checkbox"/> Rent? <input type="checkbox"/> Own? <input type="checkbox"/> Shelter? Who cares for child? _____ Date of Birth? Mother _____ Father _____ Are parents working? Mother No <input type="checkbox"/> Yes <input type="checkbox"/> Father No <input type="checkbox"/> Yes <input type="checkbox"/> Foster Care? _____ Dates: _____ Other Languages? _____																																																																																																																																																																									
FAMILY HISTORY		MEDICAL HISTORY																																																																																																																																																																									
Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had: <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">No <input type="checkbox"/></th> <th style="width: 10%; text-align: center;">Yes <input type="checkbox"/></th> <th style="width: 10%; text-align: center;">Who?</th> </tr> </thead> <tbody> <tr><td>Allergies (List) _____</td><td></td><td></td><td></td></tr> <tr><td>Asthma</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>TB/Lung Disease</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>HIV/AIDS</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>Suicide Attempts</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>Heart Disease</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>High Blood Pressure/Stroke</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>High Cholesterol</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>Blood Disorders/Sickle Cell</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>Diabetes</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>Seizures</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>Mental Illness</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>Cancer</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>Birth Defects</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>Hearing Loss</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>Speech Problems</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>Kidney Disease</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>Alcohol/Drug Abuse</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>Hepatitis/Liver Disease</td><td></td><td></td><td></td></tr> <tr><td>Thyroid Disease</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>Learning Problems/Attention Deficit Disorder</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>Family Violence</td><td>No <input type="checkbox"/></td><td>Yes <input type="checkbox"/></td><td>_____</td></tr> <tr><td>Other: _____</td><td></td><td></td><td></td></tr> </tbody> </table>			No <input type="checkbox"/>	Yes <input type="checkbox"/>	Who?	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