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: Newborn Hearing Screen? No Yes			Who lives in household? How many? Rent? Own? Shelter? Who cares for child? Date of Birth? Mother Father Are parents working? Mother No Yes Father No Yes Foster Care? Other Languages?			
FAMILY HISTORY			MEDICAL HISTORY			
Has anyone in the family (parer aunts/uncles, sisters/brothers) Allergies (List)	had:	Who?	Has your child ever had: Allergies (List) 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		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 Abuse Bone or Joint Injuries Obesity/Eating Disorders Other: Current Medication(s): (List)	No	Yes	
Reviewed by: Date of Review:						