

Maryland Healthy Kids Program Medical/Family History Questionnaire

Patient Name: _____		Date of Birth: _____																																																																																													
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: _____		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		HEALTH HISTORY																																																																																													
Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had: <table style="width: 100%; border: none;"> <tr> <td style="width: 80%;"></td> <td style="text-align: right; padding-right: 20px;">Who?</td> </tr> <tr> <td>TB/Lung Disease</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td>HIV/AIDS</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td>Suicide Attempts</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td>Heart Disease</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td>High Blood Pressure/Stroke</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td>High Cholesterol</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td>Blood Disorders/Sickle Cell</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td>Diabetes</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td>Seizures</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td>Allergies/Asthma</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td>Mental Illness</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td>Cancer</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td>Birth Defects</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td>Hearing/Speech Problems</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td>Kidney Disease</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td>Alcohol/Drug Abuse</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td>Hepatitis/Liver Disease</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td>Thyroid Disease</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td>Learning Problems/Attention Deficit Disorder</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td>Family Violence</td> <td>No <input type="checkbox"/> Yes <input type="checkbox"/> _____</td> </tr> <tr> <td colspan="2">Other: _____</td> </tr> </table>			Who?	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