Rush-Copley Medical Group

Patient Health Questionnaire

IDN13150147

Newborn to Adolescent Medical History Form

Name _____ **Birthdate** _____ **Sex: M F Today's Date**_____

Form Completed By _____ **Relationship to patient**_____ **Date Completed** _____

Child's primary caretaker(s) _____ **Legal Guardian(s)** _____

Immediate Family Information:

Name	Relationship	Age	Lives in same house?	Marital status	Race	Occupation
	Mother		**Yes / No**			
	Father		**Yes / No**			
			Yes / No			
			Yes / No			
			Yes / No			

Birth History:

Birthweight _____Type of delivery? □ Vaginal □ Cesarean Why? _____

Length of pregnancy in weeks_____ Any health problems in mother during pregnancy?_____

Complications during pregnancy? □ Yes □ No if yes explain_____

During pregnancy did mother Smoke? □ Yes □ No Drink Alcohol? □ Yes □ No

Use illicit drugs □ Yes □ No If yes what and when: _____

Use any medications? □ Yes □ No If yes what and when: _____

Did baby have any problems after birth? □ Yes □ No If yes explain: _____

Newborn feeding □ Breast □ Formula Hepatitis B vaccine given to baby in hospital? □ Yes □ No

Past Medical History:

Does your child take any medications or over the counter supplements regularly: Please list all below with doses:

Medication/Supplement Name	Dose	How often	Reason for use

Allergies to medications and reactions if known: _____

_____

Surgeries your child has had with date:

Surgery	Date	Surgeon	Hospital

Immunization History (you may skip if full immunization records are available today):

Is your child up to date with all immunizations? □ yes □ no □ unsure

Has you child had the chickenpox vaccine? □ yes, once □ yes, twice □ no □ unsure

Has your child had the meningitis vaccine (usually as teenagers)? □ yes □ no □ unsure

Has your child had the HPV vaccine (three times, girls only – usually 9-26 years old):? □ yes □ no □ unsure

Has your child ever had the flu vaccine (recommended age 6-59 months)?: □ yes □ no □ unsure

Has your child ever had the Hepatitis A vaccine?: (recommended from 1-2 year old, encouraged 2-18): □ yes □ no

Medical & Family History:

	Patient	**Family member**	**Additional information**
Asthma			
Allergies			
Heart Disease before 50 years of age			
Diabetes			
High Blood pressure before 50 years of age			
High Cholesterol			
Development/Behavior problems			
Anemia			
Bleeding disorder			
Liver disease			
Kidney disease			
Seizures			
Bedwetting (after 10)			
Alcohol or drug abuse			
Mental illness			
Mental retardation			
Deafness			
Arthritis			
Cancer and type			
Birth defects			
Early childhood death			
Immune problems or HIV or AIDS			
Tuberculosis			
Other			

Tobacco use in home? □ Yes □ No□ Outside use only

Lead Risk: Age of Home_____ Zip Code_____

Reviewed by: _____

Signature Date