Medical History Questionnaire

Pediatric/Family (Birth-21 years) page 1 of 2

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Date			
Patient Name	Sex (circle one) M F	Date of Birth	Today's Date:
Form Completed By:	Informant (guardian, parent):		

CHILD'S MEDICAL HISTORY

Has your child ever had:

Allergies (List) (Food or Meds)	☐ No	☐ Yes
Asthma/Wheezing	☐ No	☐ Yes
Has child used Nebulizer before	☐ No	☐ Yes
Pneumonia requiring Hospitalization	☐ No	☐ Yes
Chicken Pox (Year) _____	☐ No	☐ Yes
Frequent Ear Infections	☐ No	☐ Yes
Hearing Problems or Speech Problems	☐ No	☐ Yes
Vision Problems or Cross Eye	☐ No	☐ Yes
Skin Disease /Eczema/Hives	☐ No	☐ Yes
Tuberculosis/Lung Disease	☐ No	☐ Yes
Seizures/Epilepsy or Febrile seizure	☐ No	☐ Yes
Migraine Headache	☐ No	☐ Yes
Mennigitis or Brain Injury	☐ No	☐ Yes
High Blood Pressure	☐ No	☐ Yes
Heart Defects/Disease/Heart Murmur	☐ No	☐ Yes
High Cholestrol or triglyceride	☐ No	☐ Yes
Liver Disease/Hepatitis or stomach disease	☐ No	☐ Yes
Any Sickle cell or Thalasemia or other Anemia	☐ No	☐ Yes
Any Bleeding problems or hemophilia	☐ No	☐ Ye
Kidney Disease	☐ No	☐ Yes
Urinary Tract Infections	☐ No	☐ Yes
Physical or Learning Disabilities	☐ No	☐ Yes
History of developmental Delay	☐ No	☐ Yes
Speech Delay	☐ No	☐ Yes
Depression/Suicidal Thoughts	☐ No	☐ Yes
Any Hospitalizations/Surgeries	☐ No	☐ Yes
Broken Bones which?_____	☐ No	☐ Yes
Any Ligament or joint injury	☐ No	☐ Yes
Diabetes or any thyroid problems	☐ No	☐ Yes
Eating Disorders	☐ No	☐ Yes
Anorexia Nervosa or Bulimia	☐ No	☐ Yes
Attention Deficit Disorder, ADD or ADHD	☐ No	☐ Yes
Lead Poisoning	☐ No	☐ Yes

If yes to any above questions, explain below in details

_____

_____

Current Medication(s): (List):

_____

_____

_____

_____

Reviewed by:

FAMILY MEDICAL HISTORY

Has any parent (P), grandparent (GP), aunt (A), uncle (U), sister (S), or brother (B) had:

Allergies (List)	☐ No	☐ Yes	Who?
Asthma/Wheezing	☐ No	☐ Yes	Who?
TB/Lung Disease	☐ No	☐ Yes	Who?
Cystic Fibrosis	☐ No	☐ Yes	Who?
HIV/AIDS	☐ No	☐ Yes	Who?
Suicide Attempts	☐ No	☐ Yes	Who?
Heart Disease	☐ No	☐ Yes	Who?
Sudden Cardiac Death	☐ No	☐ Yes	Who?
High Blood Pressure/Stroke	☐ No	☐ Yes	Who?
High Cholesterol	☐ No	☐ Yes	Who?
Blood Disorders	☐ No	☐ Yes	Who?
Sickle Cell	☐ No	☐ Yes	Who?
Anemia	☐ No	☐ Yes	Who?
Thalassemia	☐ No	☐ Yes	Who?
Clotting Disorders	☐ No	☐ Yes	Who?
Diabetes	☐ No	☐ Yes	Who?
Seizures	☐ No	☐ Yes	Who?
Mental Illness	☐ No	☐ Yes	Who?
Depression	☐ No	☐ Yes	Who?
Suicide Attempts	☐ No	☐ Yes	Who?
Cancer	☐ No	☐ Yes	Who?
Breast	☐ No	☐ Yes	Who?
Cervical	☐ No	☐ Yes	Who?
Colorectal	☐ No	☐ Yes	Who?
Other _____			
Birth Defects	☐ No	☐ Yes	Who?
Hearing Loss	☐ No	☐ Yes	Who?
Speech Problems	☐ No	☐ Yes	Who?
Kidney Disease	☐ No	☐ Yes	Who?
Alcohol/Drug Abuse	☐ No	☐ Yes	Who?
Hepatitis/Liver Disease	☐ No	☐ Yes	Who?
Thyroid Disease	☐ No	☐ Yes	Who?
Learning Problems	☐ No	☐ Yes	Who?
Attention Deficit Disorder	☐ No	☐ Yes	Who?
Mental Retardation	☐ No	☐ Yes	Who?
Family Violence	☐ No	☐ Yes	Who?

Other Concerns:

_____

_____

Has any family member ever had an unexplained, unexpected death before age 50?

☐ No ☐ Yes (if yes, describe on back)

Date of Review:

continued >

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Pediatric/Family (Birth-21 years) page 2 of 2

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Patient Name _____Date of Birth_____

Birth History:

Type of Delivery □ vaginal □ c-sec □ adopted
Birth Weight ____lb ____oz □ Full Term or □ Premature____wks
If premature: How Many weeks Gestional age_____
How long did baby stay in hospital _____
What complications during hospital stay and afterward:

Did baby stayed in hospital longer than mother □ No □Yes
Any of following complication during newborn period
Jaundice □ No □ Yes
Heart Murmur □ No □ Yes
Infection/antibiotic use □ No □ Yes
Breathing problems or on oxygen □ No □ Yes
Birth Defects □ No □ Yes
Others_____

Social History:

Who lives at home?

Name	relationship	age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are your child's parents □Married □Divorced □Unmarried □Separted
Does your child go to school or day care center □No □Yes
What grade_____
Does any household members smoke □No □Yes
Smoke outside only □No □Yes
Any pets/animals at home □No □Yes
which_____

BF 1-Week Developmental Surveillance

Name of Child_____ Date of Birth_____

Person Filling out Form _____Today's Date_____

1. Is your newborn able to sustain periods of wakefulness for feeding?	Yes	No
2. Does your newborn seem aware of his surroundings?	Yes	No
3. Does your newborn turn and calm to your voice?	Yes	No
4. Does your newborn communicate needs through his behaviors?	Yes	No
5. Does your newborn cry?	Yes	No
6. Is your newborn able to fix briefly on faces or objects?	Yes	No
7. Does your newborn follow your face (to midline) with his eyes when you move?	Yes	No
8. Is your newborn able to suck, swallow, and breathe?	Yes	No
9. Does your newborn show strong primitive reflexes (suck, root, grasp, step, Moro, tonic neck)?	Yes	No
10. Is your newborn able to lift his head briefly when in a prone position (on his tummy)?	Yes	No
11. Do you have any other specific concerns about your newborn's development, learning, or behavior?	Yes	No

If so, what are those concerns?

BF 1-Month Developmental Surveillance

Name of Child_____ Date of Birth_____

Person Filling out Form _____Today's Date_____

1.	Is your infant responsive to calming actions when upset?	Yes	No
2.	Is your infant able to follow you with his eyes?	Yes	No
3.	Does your infant recognize your voice?	Yes	No
4.	Has your infant started to smile?	Yes	No
5.	Does your infant attempt to lift his head when on his tummy?	Yes	No
6.	Do you have any other specific concerns about your infant's development, learning, or behavior?	Yes	No

If so, what are those concerns?

BF 2-Month Developmental Surveillance

Name of Child_____ Date of Birth_____

Person Filling out Form _____Today's Date_____

1.	Does your infant attempt to look at you?	Yes No
2.	Does your infant smile?	Yes No
3.	Can your infant console and comfort himself?	Yes No
4.	Has your infant started to cry differently when hungry, uncomfortable, or tired?	Yes No
5.	Does your infant coo?	Yes No
6.	Does your infant have clearer behaviors to indicate needs for food, sleep, play, confort?	Yes No
7.	Does your infant indicate boredom (crying/fussiness) when no changes in activity occur?	Yes No
8.	Is your infant able to hold his head up and begin to push up in prone position (tummy)?	Yes No
9.	Does your infant have consistent head control in a supported sitting position?	Yes No
10.	Does your infant show symmetrical movements of head, arms, and legs?	Yes No
11.	Does your infant show diminishing newborn reflexes?	Yes No
12.	Do you have any other specific concerns about your infant's development, learning, or behavior?	Yes No

If so, what are those concerns?

BF 4-Month Developmental Surveillance

Name of Child_____ Date of Birth_____

Person Filling out Form _____Today's Date_____

1.	Does your infant smile spontaneously?	Yes No
2.	Does your infant attempt to attract your attention for social contact?	Yes No
3.	Does your infant have an increasing ability to self-calm?	Yes No
4.	Does your infant cry differently to express hunger, pain, and fatigue?	Yes No
5.	Does your infant babble more expressively and spontaneously	Yes No
6.	Does your infant respond to affection and changes in environment?	Yes No
7.	Does your infant indicate pleasure and displeasure?	Yes No
8.	Can your infant push his chest up to the elbows?	Yes No
9.	Does your infant have good head control?	Yes No
10.	Does your infant demonstrate symmetrical movements of arms and legs?	Yes No
11.	Has your infant begun to roll and reach for objects?	Yes No
12.	Do you have any other specific concerns about your child's development, learning, or behavior?	Yes No

If so, what are those concerns?

BF 6-Month Developmental Surveillance

Name of Child_____ Date of Birth_____

Person Filling out Form _____Today's Date_____

1. Does your infant interact with you socially? Yes No
2. Does your infant recognize familiar faces and begin to recognize that someone is a stranger? Yes No
3. Does your infant string vowels together ("ah", "eh", "oh") and enjoy Vocal turn-taking? Yes No
4. Is your infant beginning to recognize his own name? Yes No
5. Does your infant explore his environment both visually and orally? Yes No
6. Can your infant roll over and sit? Yes No
7. In a prone position (tummy), can your infant gradually move into crawling position? Yes No
8. Does your infant rock back and forth in a crawling position? Yes No
9. Can your infant rotate while sitting and eventually move to crawling position? Yes No
10. Do you have any other specific concerns about your infant's development, learning, or behavior? Yes No

    If so, what are those concerns?

BF 9-Month Developmental Surveillance

Name of Child_____ Date of Birth_____

Person Filling out Form _____Today's Date_____

1. Has your infant developed apprehension with (scared of) strangers? Yes No
2. Does your infant seek you out for play and comfort, and as a resource? Yes No
3. Does your infant use a wide variety repetitive consonants and vowel sounds? Yes No
4. Has your infant started to point out objects? Yes No
5. Does your infant seem to understand that a hidden object is still really there (object permanence)? Yes No
6. Has your infant learned any interactive games, like "peek-a-boo" and "so big"? Yes No
7. Does your infant look at books and explore his environment physically and visually? Yes No
8. Does your infant crawl forward and backward, get to a sitting position, and begin pullling to stand? Yes No
9. Do you have any other specific concerns about your infant's development, learning, or behavior? Yes No

   If so, what are those concerns?

BF 12-Month Developmental Surveillance

Name of Child_____ Date of Birth_____

Person Filling out Form _____Today's Date_____

1. Does your child play interactive games like "peek-a-boo" and "pat-a-cake"?	Yes	No
2. Does your child imitate activities while playing?	Yes	No
3. Does your child hand you a book when he wants to hear a story?	Yes	No
4. Can your child wave "bye-bye"?	Yes	No
5. Does your child have a strong attachment to you, and is distressed on separation?	Yes	No
6. Does your child point to a desired object and watch to see whether you see it, too?	Yes	No
7. Does your child imitate vocalizations and sounds ?	Yes	No
8. Can your child speak at least 1 or 2 words?	Yes	No
9. Does your child jabber with inflections of normal speech?	Yes	No
10. Can your child follow simple directions?	Yes	No
11. Can your child identify people upon request ("Where is ___")?	Yes	No
12. Can your child bang 2 cubes held in his hands?	Yes	No
13. Can your child stand alone?	Yes	No
14. Do you have any other specific concerns about your child's development, learning, or behavior?	Yes	No

If so, what are those concerns?

BF 15-Month Developmental Surveillance

Name of Child_____ Date of Birth_____

Person Filling out Form _____Today's Date_____

1.	Does your child listen to stories?	Yes No
2.	Does your child imitate activities while playing and try to help around the house?	Yes No
3.	Does your child indicate what he wants by pulling, pointing, or grunting?	Yes No
4.	Does your child bring objects to show you?	Yes No
5.	Does your child hand you a book when he wants a story?	Yes No
6.	Can your child speak at least 2 or 3 words (other than Dada/Mama) with meaning?	Yes No
7.	Does your child understand and follow simple directions?	Yes No
8.	Is your child scribbling?	Yes No
9.	Does your child walk well, stoop and recover?	Yes No
10.	Can your child take steps backwards?	Yes No
11.	Can your child put a block in a cup?	Yes No
12.	Can your child drink from a cup he is holding himself?	Yes No
13.	Do you have any other specific concerns about your child's development, learning, or behavior?	Yes No

If so, what are those concerns?

BF 18-Month Developmental Surveillance

Name of Child_____ Date of Birth_____

Person Filling out Form _____Today's Date_____

1. Is your child generally interactive or withdrawn around other children? Yes No
2. Is your child generally friendly or aggressive (hitting, biting) around other children? Yes No
3. Does your child laugh in response to others? Yes No
4. Does your child explore on his own with you in close proximity? Yes No
5. Is your child spontaneously affectionate? Yes No
6. Does your child want to help around the house? Yes No
7. Does your child speak at least 6 words? Yes No
8. Does your child point to indicate to someone else what he wants? Yes No
9. Can your child point to at least 1 body part? Yes No
10. Can your child follow simple instructions without gestured cues ("sit down")? Yes No
11. Does your child show interest in a doll or stuffed animal by hugging it or pretend feeding? Yes No
12. Does your child know the names of his favorite books? Yes No
13. Do you think your child sees all right? Yes No
14. Do you think your child hears all right? Yes No
15. Can your child walk up steps and run? Yes No
16. Can your child stack at least 2 or 3 blocks? Yes No
17. Is your child scribbling and imitating crayon strokes? Yes No
18. Can your child use a spoon and cup without spilling most of the time? Yes No
19. Do you have any other specific concerns about your child's development, learning, or behavior? If so, what are those concerns? Yes No

BF 30-Month Developmental Surveillance

Name of Child_____ Date of Birth_____

Person Filling out Form _____Today's Date_____

1. Does your child engage in increasing imaginary play with dolls and toys? Yes No
2. Does your child increasingly include other children in his play (tea parties, chase games)? Yes No
3. Does your child have fears about unexplained changes/unexpected events? Yes No
4. Does your child use short phrases of 3-4 words? Yes No
5. Is your child understandable to others at least 50% of the time? Yes No
6. Does your child know the correct actions for animals/people (dog barks, bird flies, etc)? Yes No
7. Does your child have friends? Yes No
8. Can your child point to at least 6 body parts? Yes No
9. Can your child jump up and down in place? Yes No
10. Can your child throw a ball overhand? Yes No
11. Can your child wash and dry his hands? Yes No
12. Can your child brush his teeth with help? Yes No
13. Can your child put on clothes with help? Yes No
14. Can your child copy a vertical line? Yes No
15. Do you have any other specific concerns about your child's development, learning, or behavior? Yes No

    If so, what are those concerns?

BF 24-Month Developmental Surveillance

Name of Child_____ Date of Birth_____

Person Filling out Form _____Today's Date_____

1. Does your child imitate adults?	Yes	No
2. Does your child engage in pretend play (rocking, feeding, putting doll/stuffed animal to bed)?	Yes	No
3. Does your child play alongside other children (parallel play)?	Yes	No
4. Does your child refer to himself as "I" or "me"?	Yes	No
5. Does your child have a special attechment to any transitional objects?	Yes	No
6. Does your child have a vocabulary of at least 50 words?	Yes	No
7. Does your child use 2-word phrases?	Yes	No
8. Does your child ask you to read a book?	Yes	No
9. Can your child follow 2-step commands?	Yes	No
10. Can your child name the object in 1 picture (cat, horse, bird, dog, man, etc)?	Yes	No
11. Does your child complete sentences/rhymes in his favorite books?	Yes	No
12. Does your child correct you if you change a word in a book he knows?	Yes	No
13. If you ask, "Where is ___?", can you child point to an object or animal in a book?	Yes	No
14. Can your child stack at least 5 or 6 blocks?	Yes	No
15. Does your child make or imitate horizontal/circular strokes with a crayon?	Yes	No
16. Does your child turn book pages one at a time?	Yes	No
17. Does your child imitate food preparation (scrubs, stirs, beats an egg, etc)?	Yes	No
18. Can your child throw a ball overhand?	Yes	No
19. Can your child go up and down stairs one at a time?	Yes	No
20. Can your child kick a ball?	Yes	No
21. Can your child jump up?	Yes	No
22. Do you have any other specific concerns about your child's development, learning, or behavior? If so, what are those concerns?	Yes	No

BF 3-Year Developmental Surveillance

Name of Child_____ Date of Birth_____

Person Filling out Form _____Today's Date_____

1. Does your child have self-care skills (can feed and dress himself)?	Yes	No
2. Has your child's imaginative play become more elaborate and detailed?	Yes	No
3. Does your child enjoy interactive play (with other children)?	Yes	No
4. Can your child carry on a conversation with 2 or 3 sentences spoken together?	Yes	No
5. Is your child understandable to others at least 75% of the time?	Yes	No
6. Can your child name a friend?	Yes	No
7. Does your child know the name and use of a cup, ball, spoon, and crayon?	Yes	No
8. Can your child identify self as a girl or a boy?	Yes	No
9. Can your child build a tower of at least 6 to 8 cubes?	Yes	No
10. Can your child throw a ball overhand?	Yes	No
11. Can your child ride a tricycle?	Yes	No
12. Can your child walk up stairs alternating feet?	Yes	No
13. Can your child balance on 1 foot for at least 1 second?	Yes	No
14. Can your child copy a circle?	Yes	No
15. Can your child draw a person with 2 body parts (head plus 1 other)?	Yes	No
16. Is your child toilet trained during the day (bowel and bladder)?	Yes	No
17. Do you have any other specific concerns about your child's development, learning, or behavior? If so, what are those concerns?	Yes	No

BF 4-Year Developmental Surveillance

Name of Child_____ Date of Birth_____

Person Filling out Form _____Today's Date_____

1. Can your child describe himself, including gender, age, interests, and strengths?	Yes	No
2. Is your child generally responsive or withdrawn?	Yes	No
3. Is your child generally friendly or hostile/aggressive?	Yes	No
4. Is your child generally cooperative or defiant?	Yes	No
5. Does your child act appropriately for community or family cultural values ?	Yes	No
6. Does your child play with favorite toys?	Yes	No
7. Does your child listen to stories?	Yes	No
8. Does your child engage in fantasy play?	Yes	No
9. Can your child give his first and last name?	Yes	No
10. Can your child sing a song or say a poem from memory?	Yes	No
11. Does your child know what to do if cold, tired, or hungry?	Yes	No
12. Is most of your child's speech clearly understandable?	Yes	No
13. Can your child name 4 colors?	Yes	No
14. Is your child aware of gender (of self and others)?	Yes	No
15. Does your child play board/card games?	Yes	No
16. Can your child draw a person with at least 3 parts?	Yes	No
17. Can your child tell you what he thinks will happen next in a book?	Yes	No
18. Can your child hop on one foot?	Yes	No
19. Can your child balance on one foot for at least 2 seconds?	Yes	No
20. Can your child build a tower of at least 8 blocks?	Yes	No
21. Can your child copy a cross?	Yes	No
22. Can your child pour, cut, and mash his own food?	Yes	No
23. Can your child brush his own teeth?	Yes	No
24. Can your child dress himself, including buttons?	Yes	No
25. Do you have any other specific concerns about your child's development, learning, or behavior? If so, what are those concerns?	Yes	No

BF 5-Year Developmental Surveillance

Name of Child_____ Date of Birth_____

Person Filling out Form _____Today's Date_____

1. Can your child balance on one foot, hop, and skip?	Yes	No
2. Can your child tie a knot?	Yes	No
3. Does your child have a mature pencil grasp?	Yes	No
4. Can your child draw a person with at least 6 body parts?	Yes	No
5. Can your child print some letters and numbers?	Yes	No
6. Can your child copy squares and triangles?	Yes	No
7. Does your child have good articulation (speaks clearly)?	Yes	No
8. Can your child tell a simple story using full sentences?	Yes	No
9. Does your child use appropriate tenses and pronouns?	Yes	No
10. Can your child count to 10?	Yes	No
11. Can your child name at least 4 colors?	Yes	No
12. Can your child follow simple directions?	Yes	No
13. Is your child able to listen and pay attention?	Yes	No
14. Can your child dress and undress with minimal assistance?	Yes	No
15. Do you have any other specific concerns about your child's development, learning, or behavior?	Yes	No

If so, what are those concerns?

Gaurang Patel MD FAAP & Jigisha Chaudhary MD FAAP

NAME_____ DATE OF BIRTH_____ TODAY'S DATE_____

M-CHAT 18 months or 24 months

Please fill out the following about how your child **usually** is. Please try to answer every question. If the behavior is rare (e.g., you've seen it once or twice), please answer as if the child does not do it. (Please ignore the number on left side of column)

2.	Does your child take an interest in other children?	Yes	No
7.	Does your child ever use his/her index finger to point, to indicate interest in something?	Yes	No
9.	Does your child ever bring objects over to you (parent) to show you something?	Yes	No
13.	Does your child imitate you? (e.g., you make a face—will your child imitate it?)	Yes	No
14.	Does your child respond to his/her name when you call?	Yes	No
15.	If you point at a toy across the room, does your child look at it?	Yes	No
1.	Does your child enjoy being swung, bounced on your knee, etc.?	Yes	No
3.	Does your child like climbing on things, such as up stairs?	Yes	No
4.	Does your child enjoy playing peek-a-boo/hide-and-seek?	Yes	No
5.	Does your child ever pretend, for example, to talk on the phone or take care of dolls, or pretend other things?	Yes	No
6.	Does your child ever use his/her index finger to point, to ask for something?	Yes	No
8.	Can your child play properly with small toys (e.g., cars or bricks) without just mouthing, fiddling, or dropping them?	Yes	No
10.	Does your child look you in the eye for more than a second or two?	Yes	No
12.	Does your child smile in response to your face or your smile?	Yes	No
16.	Does your child walk?	Yes	No
17.	Does your child look at things you are looking at?	Yes	No
19.	Does your child try to attract your attention to his/her own activity?	Yes	No
21.	Does your child understand what people say?	Yes	No
23.	Does your child look at your face to check your reaction when faced with something unfamiliar?	Yes	No
11.	Does your child ever seem oversensitive to noise? (e.g., plugging ears)	Yes	No
18.	Does your child make unusual finger movements near his/her face?	Yes	No
20.	Have you ever wondered if your child is deaf?	Yes	No
22.	Does your child sometimes stare at nothing or wander with no purpose?	Yes	No

Reviewed by:_____

Action taken:_____

_____

_____