MIT Medical Department — Pediatrics History Form

Dear Parent:

This is a health questionnaire on your child. **Please complete this form. Bring it with you at the time of an appointment.**

Date completed:________________

Child's Name: ____ Date of Birth: ______________________________

Mother's Name: ______________________________________ Father/ Partner: ____________________________

Home Address: ____

Home Phone: _________________________________ Work Phone: _____________________________________

This child lives with: ❏ Mother ❏ Mother/Father ❏Mother/Partner ❏ Father/Partner ❏ Grandparent/Other

FAMILY HISTORY

1. Mother Age: __________ Current Health: ____

   Past Health Problems: ____

2. Father/ Partner Age: __________ Current Health: ____

   Past Health Problems: ____

3. Marital Status of Parents: ____

   M.I.T. Affiliation: ____

4. Other Children in Family:

	Dates of Birth	Name	State of Health
•	___________	________________________________	____________
•	___________	________________________________	____________
•	___________	________________________________	____________
•	___________	________________________________	____________

5. Are there cultural or religious practices that might affect your child's medical care? ❏ yes ❏ no

   If yes, please explain: (examples: blood transfusion, dietary rules):_______________________________________

   ____

   ____

6. Is there a history in the **family/ a blood relative** of:
   a. Tuberculosis ❏ yes ❏ no
   b. Diabetes ❏ yes ❏ no
   c. Asthma, hay fever, eczema, allergies ❏ yes ❏ no
   d. Mental Disorder ❏ yes ❏ no
   e. Seizures ❏ yes ❏ no
   f. Hepatitis ❏ yes ❏ no
   g. Heart disease, stroke, high cholesterol ❏ yes ❏ no
   h. Cancer ❏ yes ❏ no
      If yes, what kind: ____
   i. Birth defects, genetic defects ❏ yes ❏ no
   j. Other serious medical problems ❏ yes ❏ no

PRENATAL HISTORY

1. While pregnant, did mother have:
   a. High blood pressure ❑ yes ❑ no
   b. Bleeding or spotting ❑ yes ❑ no
   c. Kidney Disease ❑ yes ❑ no
   d. Toxemia ❑ yes ❑ no
   e. Gestational diabetes ❑ yes ❑ no
   f. Threatened Miscarriage ❑ yes ❑ no
   g. German Measles (Rubella) ❑ yes ❑ no
   h. Illness other than cold or flu ❑ yes ❑ no
   i. Premature labor ❑ yes ❑ no

2. Were medications or herbs taken during pregnancy? ❑ yes ❑ no
   If yes, what kind: ______________________________

3. Was a fertility treatment used for this pregnancy? ❑ yes ❑ no
   If yes, what kind: ______________________________

BIRTH HISTORY

1. Where was baby born: ______________________________

2. Was labor induced: ❑ yes ❑ no

3. Was labor helped by medication: ❑ yes ❑ no

4. Duration of labor: ______________________________

5. Was baby born early: (less than 38 weeks) ❑ yes ❑ no

6. Was baby born late (after 42 weeks) ❑ yes ❑ no

7. What was the method of delivery ❑ yes ❑ no
   ❑ Spontaneous vaginal
   ❑ Forceps
   ❑ Breech
   ❑ Caesarean Reason: ______________________________

8. Birth weight of baby: ______________________________

9. Apgar score, if known: ______________________________

10. During hospital stay, did baby have any of the following:
    a. Jaundice ❑ yes ❑ no
    b. Antibiotic treatment ❑ yes ❑ no
    c. Rash ❑ yes ❑ no
    d. Blue spells ❑ yes ❑ no
    e. Convulsions ❑ yes ❑ no
    f. Did baby remain in hospital longer than mother? ❑ yes ❑ no

11. How was baby fed?
    ❑ Breast
    ❑ Bottle

DEVELOPMENTAL HISTORY:

1. At what age did child: Age
   a. Hold up head ________
   b. Roll over ________
   c. Sit unsupported ________
   d. Stand alone ________
   e. Walk ________
   f. Talk ________
   g. Toilet train ________
   h. Feed her/himself ________
   i. Dress her/himself ________

IMMUNIZATIONS

PLEASE GIVE US A COPY OF PREVIOUS IMMUNIZATIONS/VACCINES
and TB (Tuberculosis) Testing or BCG Vaccination

PAST MEDICAL HISTORY:

1. Has the child had:
   - a. Chicken pox ❑ yes ❑ no
   - b. Measles (Rubeola) ❑ yes ❑ no
   - c. German Measles (Rubella) ❑ yes ❑ no
   - d. Mumps ❑ yes ❑ no
   - e. Meningitis ❑ yes ❑ no
   - f. Convulsions ❑ yes ❑ no
   - g. Contusions ❑ yes ❑ no
   - h. Fractures ❑ yes ❑ no
   - i. Poison Ingestion ❑ yes ❑ no
   - j. Operations ❑ yes ❑ no
   - k. Blood transfusions ❑ yes ❑ no
   - l. Blood: anemia (iron deficiency, Sickle Cell, Thalassemia) ❑ yes ❑ no
   - m. Hospitalizations ❑ yes ❑ no
     If yes, what illness? ______________________________________
   - n. Other serious medical illnesses: ❑ yes ❑ no
     If yes, what kind? ____
   - o. Is your child currently taking any medications, vitamins, or herbs: ❑ yes ❑ no

Medications	Strength or dose	How often
______________	______________	___________
______________	______________	___________
______________	______________	___________

   - p. Reaction to drug or foods (allergy) ❑ yes ❑ no
     If yes, please explain:____
     ____
   - q. Any chronic or recurring pain? ❑ yes ❑ no
     If yes, please explain:____
     ____

2. Eyes:
   - a. Any visual problems? ❑ yes ❑ no
   - b. Do eyes look crossed? ❑ yes ❑ no
   - c. Does the child wear glasses? ❑ yes ❑ no

3. Ears:
   - a. Any hearing problems? ❑ yes ❑ no
   - b. Three or more ear infections? ❑ yes ❑ no

4. Nose:
   - a. Does the child have frequent attacks of sneezing or rubbing his/her nose? ❑ yes ❑ no
   - b. Has the child had frequent nose bleeds? ❑ yes ❑ no

5. Throat:
   - a. Does your child have three or more strep throat infections per year? ❑ yes ❑ no

6. Heart:: Have you ever been told your child has:
   - a. A heart murmur ❑ yes ❑ no
   - b. High blood pressure ❑ yes ❑ no
   - c. Heart defect ❑ yes ❑ no

7. Lungs: Has your child ever had:
   a. Bronchitis or pneumonia ❑ yes ❑ no
   b. Asthma/wheezing ❑ yes ❑ no
   c. Chronic cough ❑ yes ❑ no

8. Does your child tire easily? ❑ yes ❑ no

9. Abdomen: Has your child ever had:
   a. Jaundice ❑ yes ❑ no
   b. Blood in bowel movement ❑ yes ❑ no
   c. Frequent abdominal pain ❑ yes ❑ no
   d. Frequent vomiting or diarrhea ❑ yes ❑ no
   e. Marked weight loss ❑ yes ❑ no
   f. Difficulty with appetite or eating?
      If yes, please explain:____

      ____

10. Kidney:
   a. Has your child ever had a urinary tract infection? ❑ yes ❑ no
   b. Has there ever been blood in the urine? ❑ yes ❑ no
   c. Does your child ever wet the bed? ❑ yes ❑ no
   d. Does your child ever complain of burning or frequency of urination? ❑ yes ❑ no

11. Skin:
   a. Any sensitivity or allergy? ❑ yes ❑ no
   b. Eczema or atopic dermatitis? ❑ yes ❑ no
   c. Acne? ❑ yes ❑ no

12. Extremities: Has your child:
   a. Had weakness or paralysis of arms or legs? ❑ yes ❑ no
   b. A persistent limp? ❑ yes ❑ no
   c. Ever worn corrective shoes or braces ❑ yes ❑ no

13. Neurological: Has your child ever had
   a. Frequent headaches ❑ yes ❑ no
   b. Convulsions or seizures ❑ yes ❑ no
   c. Dizziness ❑ yes ❑ no
   d. Fainting ❑ yes ❑ no
   e. Breath holding ❑ yes ❑ no
   f. Temper tantrums ❑ yes ❑ no

14. Is your child
   a. Overactive ❑ yes ❑ no
   b. Impulsive ❑ yes ❑ no
   c. Lacking in self control ❑ yes ❑ no
   d. Does your child have problems with:
      - Peers ❑ yes ❑ no
      - Siblings ❑ yes ❑ no
      - Parents ❑ yes ❑ no
      - Sleep ❑ yes ❑ no
      - Attention span ❑ yes ❑ no
      - Attending school ❑ yes ❑ no
      - Learning ❑ yes ❑ no
      - Mood ❑ yes ❑ no
   e. Are there concerns about physical, sexual, or emotional abuse? ❑ yes ❑ no

(You may call **Mental Health Services** to set up an evaluation at 617-253-2916 for any of the above.)

15. Has your child begun puberty? ❑ yes ❑ no

16. Any other concerns you would like to discuss?____

______________________________ ______________________________
Parent signature Date Provider name Date reviewed