Pediatric Care, Inc.

Original Date:

800 Compton Road Suite 25, Cincinnati, Ohio 45231
8752 Union Centre Blvd., West Chester, Ohio 45069

MEDICAL HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Patient's Name	☐ M ☐ F	**DOB:**
Mother's Name		**DOB:**
Father's Name		**DOB:**
List All Siblings		

BIRTH HISTORY

Type of Delivery: ____Vaginal ____Cesarean _____Full-term _____Premature _____Weeks Gestation

Please List Any Birth Complications:

Name of Hospital: Hep B given at Birth _____Yes _____No Newborn Hearing Screen_____Yes _____No

Birth Weight: _____lbs. _____oz. Discharge Weight:_____lbs _____oz. Length:_____ Head Circumference _____ Apgars _____

Breastfeeding _____Yes _____No Formula Type_____

FAMILY & ENVIRONMENTAL HISTORY (Please List Details)

Family History:	☐ Hypertension/Cholesterol Risk/Heart Problems _____	
	☐ Cancer _____ ☐ Diabetes _____ ☐ Seizures _____	
	☐ Allergies_____ ☐ Asthma/Respiratory Problems _____	
	☐ Headaches _____ ☐ Depression/Mental Health/Academic Issues _____	
	☐ Anemia/blood disorders _____	
	☐ Other _____	☐ **None of these Conditions exist**
Environmental History:	Does anyone in your house smoke? _____	Do you have any pets (please list) _____
	Was your home built before 1970? _____	

PATIENT MEDICAL HISTORY (Please List Details)

☐ Allergies

☐ Chicken Pox

☐ Hospitalizations/Surgeries

☐ Illnesses/Chronic Conditions

☐ Other