

## Medical Information Regarding Your Child

*Please answer all pertinent questions to your child*

**Patient Name:** \_\_\_\_\_ **DOB/ Age:** \_\_\_\_\_

**Person filling up this questionnaire:**  Mother  Father  Other \_\_\_\_\_

**Primary Physician/ Other MD:** \_\_\_\_\_

**Have you been seen by:**  PAMF  Sutter  UCSF  Kaiser  Other \_\_\_\_\_

**Reason of Visit:** \_\_\_\_\_

**Allergies to Medications / food / environmental:**

Name: \_\_\_\_\_ Reaction: \_\_\_\_\_

Name: \_\_\_\_\_ Reaction: \_\_\_\_\_

**Patient Medical History:**

	Yes	No		Yes	No		Yes	No
Anemia			<b>Weight loss</b>			<b>Skin Rash</b>		
Celiac			Poor Appetite			Eczema		
Gallbladder Stones			Fatigue			Hives		
Constipation			Fever			<b>Asthma</b>		
Chronic Diarrhea			Nighttime sweating			Chronic Cough		
Crohn's disease			<b>Bladder/Kidney Infection</b>			Recurrent Pneumonia		
Stools Soiling			Urine accidents			<b>Diabetes</b>		
Food Intolerance			Kidney disease			Thyroid disease		
GERD			<b>Nosebleeds</b>			<b>Heart Disease</b>		
Hepatitis			Hearing Loss			Chest Pain		
Ulcerative Colitis			Recurrent Canker Sores			Blood Pressure		
<b>Abdominal Pain</b>			Recurrent Sinusitis			Dizziness		
Rectal Bleeding			Seasonal Allergy			<b>Depression</b>		
Nausea			<b>Seizure</b>			Anxiety		
Vomiting			Migraines			Suicidal		
Trouble swallowing			Headache			Eating Disorder		
Heartburn			Cerebral Palsy			Substance Abuse		
Bloating			<b>Bleeding Disorder</b>			Smoking		
Jaundice			<b>Joint Pain / Swelling</b>			Alcohol		
<b>Eye Disease</b>			Back Pain			<b>Irregular Menses</b>		

**Surgical History:**

	Yes	No		Yes	No		Yes	No
Appendectomy			Fundoplication			Liver Biopsy		
Gallbladder			Colonoscopy			Hospitalization		If yes, what's for?
G tube			Endoscopy			Other significant		If yes, what?

**Family History:**

Relationship														
	Mother	Father	Sister	Brother	Mat Aunt	Mat Uncle	Pat Aunt	Pat Uncle	Mat Grd M	Mat Grd F	Pat Grd M	Pat Grd F	Other	
Ulcerative Colitis														
Crohn's disease														
Colon Polyp														
Hepatitis														
Liver Disease														
Jaundice														

Relationship	Mother	Father	Sister	Brother	Mat Aunt	Mat Uncle	Pat Aunt	Pat Uncle	Mat Grd M	Mat grd F	Pat Grd M	Pat Grd F	
Gallbladder Disease													
Celiac													
GERD													
Irritable Bowel Syndrome													
Constipation													
Ulcers													
H. Pylori													
Stomach /intestine / liver Cancer													
HIV													
Tuberculosis													
Food Allergy													
Asthma													
Skin disease													
Thyroid disease													
Diabetes Insulin Depend													
Blood disorder													
Autoimmune disease													
Psychiatry disease													
Other Significant													

**Social History:**

Are the Parents Separated?  No  Yes  Other \_\_\_\_\_

Who does the patient live with: \_\_\_\_\_

Education: \_\_\_\_\_

Activity: \_\_\_\_\_

How Many hours spend on electronics (TV / Phone/ games/ computers) daily? \_\_\_\_\_

**Current Medications:** Names and Dosage including Prescribed, OTC, Vitamins, Herbal Medications:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Preferred Laboratory Name:** \_\_\_\_\_ **Recent Lab done**  Yes  No

**Preferred Pharmacy Name/ Location:** \_\_\_\_\_

**Diet:** How many oz. of milk or Formula or Pediasure Daily: \_\_\_\_\_

How many oz. of Soda/ juice / sports drink daily: \_\_\_\_\_

Does the patient eat fiber diet?  Yes  Limited  Other \_\_\_\_\_

Is Patient lactose Intolerant?  No  Yes \_\_\_\_\_

Does the patient have a special diet?  No  Yes: \_\_\_\_\_

Does the patient eat fast or slow?  Slow  Fast  Average  other: \_\_\_\_\_

**Birth History if less than 2 years of age:** Birth Weight / Height: \_\_\_\_\_

Is the patient premature?  No  Yes: How many weeks? \_\_\_\_\_

Did the Patient require extra days of Hospitalization at birth?  No  Yes: \_\_\_\_\_

**Not Mandatory:** Ethnicity:  Hispanic  Non-Hispanic

Religion: \_\_\_\_\_ Race: \_\_\_\_\_