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:_____
Contact Information for Parent 1
Name:_____ Email:_____
Home Address:_____
Home Phone:_____ Work Phone:_____ Cell/Other:_____
Contact Information for Parent 2
Name:_____ Email:_____
Home Address:_____
Home Phone:_____ Work Phone:_____ Cell/Other:_____
This child lives with: □ Mother □ Father □ Mother/Father □Mother/Partner □ Father/Partner □ Grandparent/Other
MIT Affiliation
Person:_____ Position:_____ Department:_____

FAMILY HISTORY

1. Parent 1 Age:_____ Current Health:_____
   Past Health Problems:_____
   Ethnicity:_____ Education/Training:_____
2. Parent 2 Age:_____ Current Health:_____
   Past Health Problems:_____
   Ethnicity:_____ Education/Training:_____
3. Marital Status of Parents:_____
4. Other Children in Family:

Date of Birth	Gender	Name	Healthy or Medical Issues?

5. Are there cultural or religious practices that might affect your child's medical care? □ no □ yes
   If yes, please explain (e.g. blood transfusion, dietary rules, etc.):_____
6. Is there tobacco use in/around your household? □ no □ yes
7. Is there a history in the **family/a blood relative** of:

			If yes, state relationship to child
a. Allergies	□ no	□ yes	
b. Anxiety	□ no	□ yes	
c. Asthma	□ no	□ yes	
d. Birth Defects/Genetic Problems	□ no	□ yes	
e. Cancer			
i. Brain	□ no	□ yes	
ii. Breast	□ no	□ yes	
iii. Colon	□ no	□ yes	
iv. Ovarian	□ no	□ yes	
v. Skin	□ no	□ yes	

vi. Thyroid ☐ no ☐ yes
vii. Other (describe and state relationship to child):

f. Depression ☐ no ☐ yes
If yes, state relationship to child
g. Diabetes ☐ no ☐ yes
h. Hearing Loss ☐ no ☐ yes
i. Heart Attack ☐ no ☐ yes
j. Heart Disease ☐ no ☐ yes
k. Hepatitis ☐ no ☐ yes
l. High Blood Pressure ☐ no ☐ yes
m. High Cholesterol ☐ no ☐ yes
n. Learning Disability ☐ no ☐ yes
o. Mental Illness ☐ no ☐ yes
p. Seizures ☐ no ☐ yes
q. Thyroid Problems ☐ no ☐ yes
r. Tuberculosis ☐ no ☐ yes

PRENATAL HISTORY

1. While pregnant, did mother have:
   a. Bleeding or spotting ☐ no ☐ yes
   b. German measles (Rubella) ☐ no ☐ yes
   c. Gestational diabetes ☐ no ☐ yes
   d. High blood pressure ☐ no ☐ yes
   e. Illness other than cold/flu ☐ no ☐ yes
   f. Kidney disease ☐ no ☐ yes
   g. Premature labor ☐ no ☐ yes
   h. Threatened miscarriage ☐ no ☐ yes
   i. Toxemia ☐ no ☐ yes
2. Were medications or herbs taken during pregnancy? ☐ no ☐ yes
   If yes, what kind:
3. Was a fertility treatment used for this pregnancy? ☐ no ☐ yes
   If yes, what kind:

BIRTH HISTORY

1. Where was child born:
2. Was labor induced? ☐ no ☐ yes
3. Was labor helped by medication? ☐ no ☐ yes
4. Duration of labor:
5. Was child born early (less than 38 weeks)? ☐ no ☐ yes
6. Was child born late (after 42 weeks)? ☐ no ☐ yes
7. What was the method of delivery:
   ☐ Breech
   ☐ Caesarean (Please state reason):
   ☐ Forceps
   ☐ Spontaneous vaginal
8. Child's birth weight:
9. Apgar Score (if known):
10. During the hospital stay, did child have any of the following:
    a. Antibiotic treatment ☐ no ☐ yes
    b. Blue spells ☐ no ☐ yes
    c. Convulsions ☐ no ☐ yes
    d. Jaundice ☐ no ☐ yes
    e. Skin rash ☐ no ☐ yes
    f. Did child remain in hospital longer than mother? ☐ no ☐ yes
11. How was/is baby fed?
    ☐ Bottle
    ☐ Breast

DEVELOPMENTAL HISTORY:

1. At what age did child: Age
    a. Hold up head _____
    b. Roll over _____
    c. Sit unsupported _____
    d. Stand alone _____

    Age
    e. Walk _____
    f. Talk _____
    g. Toilet train _____
    h. Feed him/herself _____
    i. Dress him/herself _____

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. Blood: anemia (iron deficiency, Sickle Cell, Thalessemia)_____ ☐ no ☐ yes
    b. Blood transfusions_____ ☐ no ☐ yes
    c. Chicken pox (Varicella)_____ ☐ no ☐ yes
    d. Contusions_____ ☐ no ☐ yes
    e. Convulsions_____ ☐ no ☐ yes
    f. Fractures_____ ☐ no ☐ yes
    g. German Measles (Rubella)_____ ☐ no ☐ yes
    h. Hospitalizations_____ ☐ no ☐ yes
    i. Measles (Rubeola)_____ ☐ no ☐ yes
    j. Meningitis_____ ☐ no ☐ yes
    k. Mumps_____ ☐ no ☐ yes
    l. Operations_____ ☐ no ☐ yes
        If yes, what illness?_____
    m. Poison ingestion_____ ☐ no ☐ yes
    n. Other serious medical illnesses_____ ☐ no ☐ yes
        If yes, what kind?_____
    o. Is your child currently taking any medications, vitamins or herbs?_____ ☐ no ☐ yes

Medication	Strength/Dose	How Often?

    p. Reaction to medication or food (allergy)_____ ☐ no ☐ yes
        If yes, please explain:_____
    q. Any chronic or recurring pain?_____ ☐ no ☐ yes
        If yes, please explain:_____
2. Eyes:
    a. Any visual problems?_____ ☐ no ☐ yes
    b. Do eyes look crossed?_____ ☐ no ☐ yes
    c. Does the child wear eyeglasses?_____ ☐ no ☐ yes
3. Ears:
    a. Any hearing problems?_____ ☐ no ☐ yes
    b. Three or more ear infections?_____ ☐ no ☐ yes

4. Nose:
    a. Does the child have frequent attacks of sneezing or rubbing his/her nose? ☐ no ☐ yes
    b. Has the child had frequent nose bleeds? ☐ no ☐ yes
5. Throat:
    a. Does your child have three or more strep throat infections per year? ☐ no ☐ yes
6. Heart:
    Have you ever been told your child has
    a. A heart murmur? ☐ no ☐ yes
    b. Heart defect? ☐ no ☐ yes
    c. High blood pressure? ☐ no ☐ yes
7. Lungs:
    Has your child ever had
    a. Asthma/wheezing? ☐ no ☐ yes
    b. Bronchitis or pneumonia? ☐ no ☐ yes
    c. Chronic cough? ☐ no ☐ yes
8. Does your child tire easily? ☐ no ☐ yes
9. Abdomen
    Has your child ever had
    a. Blood in bowel movement? ☐ no ☐ yes
    b. Difficulty with appetite or eating? ☐ no ☐ yes
    c. Frequent abdominal pain? ☐ no ☐ yes
    d. Frequent vomiting or diarrhea? ☐ no ☐ yes
    e. Jaundice? ☐ no ☐ yes
    f. Marked weight loss? ☐ no ☐ yes
        If yes, please explain:
10. Kidney:
    a. Does your child ever complain of burning or frequency of urination? ☐ no ☐ yes
    b. Does your child wet the bed? ☐ no ☐ yes
    c. Has there ever been blood in the urine? ☐ no ☐ yes
    d. Has your child ever had a urinary tract infection? ☐ no ☐ yes
11. Skin:
    a. Acne? ☐ no ☐ yes
    b. Any sensitivity or allergy? ☐ no ☐ yes
    c. Eczema or atopic dermatitis? ☐ no ☐ yes
12. Extremities:
    Has your child
    a. Had weakness or paralysis of arms or legs? ☐ no ☐ yes
    b. A persistent limp? ☐ no ☐ yes
    c. Every worn corrective shoes or braces? ☐ no ☐ yes
13. Neurological:
    Has your child ever had
    a. Breath holding? ☐ no ☐ yes
    b. Convulsions or seizures? ☐ no ☐ yes
    c. Dizziness? ☐ no ☐ yes
    d. Fainting? ☐ no ☐ yes
    e. Frequent headaches? ☐ no ☐ yes
    f. Temper tantrums? ☐ no ☐ yes
14. Is your child:
    a. Impulsive? ☐ no ☐ yes
    b. Lacking in self-control? ☐ no ☐ yes
    c. Overactive? ☐ no ☐ yes
    d. Does your child have problems with:
        i. Attending school? ☐ no ☐ yes
        ii. Attention span? ☐ no ☐ yes
        iii. Learning? ☐ no ☐ yes
        iv. Mood? ☐ no ☐ yes
        v. Parents? ☐ no ☐ yes
        vi. Peers? ☐ no ☐ yes
        vii. Siblings? ☐ no ☐ yes

viii. Sleep?_____ ☐ no ☐ yes

e. Are there concerns about physical, sexual or emotional abuse?_____ ☐ no ☐ yes
(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?_____ ☐ no ☐ yes

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

_____

_____ _____

Parent Signature Date Provider Name Date Reviewed