



Sonia Gidwani, MD, PLLC
 Board Certified Pediatrician
 Child and Adolescent Wellness, Pediatric
 Weight Management, Pediatric Acupuncture

our kids' MD

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Medical/Family History Questionnaire

form page 1 of 2

Practice Name: _____

Patient's Name: _____

Address: _____

Source of Information: _____

Date of Entry: _____

Date of Birth: _____

Phone: _____

Emergency: _____

Relationship: _____

Area	Response	
Mother's Pregnancy/Child's Birth History: (under 2 years old)		
Illnesses during pregnancy?	N	Y
Any medications during pregnancy?	N	Y
Alcohol/Drug Abuse?	N	Y
Problems at birth?	N	Y
Describe:		
Type of delivery?	Vaginal	C-section
Birth Weights	Birth	Discharge
Did baby receive Hepatitis B vaccine?	N	Y
Date of Hepatitis B immunization		
Name of Hospital		
Was first PKU done?	N	Y

Patient's Health History: Has your child ever had..		
Measles/Mumps/Chicken Pox?	N	Y
Frequent ear infections?	N	Y
Vision/Hearing Problems?	N	Y
Skin Problems?	N	Y
Asthma/Allergies?	N	Y
TB/Lung Disease/Croup?	N	Y
Seizures/Epilepsy?	N	Y
High Blood Pressure?	N	Y
Heart Defects/Disease?	N	Y
Liver Disease/Hepatitis?	N	Y
Diabetes?	N	Y
Kidney Disease/Bladder Infections?	N	Y
Handicaps/Disabilities?	N	Y
Bleeding Disorders/Hemophilia?	N	Y
Sexually Transmitted Diseases?	N	Y
Emotional Problems/Suicide Attempts?	N	Y
Hospitalizations/Surgeries?	N	Y
Physical/Emotional Abuse/Broken bones?	N	Y

Area	Response	
Social History		
How many living in the household?		
Who cares for child?		
Who lives in household?		
School?		
Grade?		
Report Card?		
School behavior problems?		

Family History: Has anyone in the family (parents, grandparents, aunts/uncles, sisters/brothers, cousins, etc.) had the following:		
TB/Lung Disease?	N	Y
HIV/AIDS?	N	Y
Suicide Attempts?	N	Y
Heart Disease?	N	Y
High Blood Pressure?	N	Y
High Cholesterol?	N	Y
Blood Disorders?	N	Y
Diabetes?	N	Y
Seizures?	N	Y
Allergies/Asthma?	N	Y
Mental Illness?	N	Y
Mental Retardation?	N	Y
Cancer?	N	Y
Birth Defects?	N	Y
Hearing Speech Problems?	N	Y
Kidney Disease?	N	Y



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Medical/Family History Questionnaire form page 2 of 2

Patient Name: _____

Area	Response	
Alcohol/Drug Abuse?	N	Y
Stroke?	N	Y
Hepatitis/Liver Disease?	N	Y
Thyroid Disease?	N	Y
Learning Problems?	N	Y
Attention Deficit Disorder?	N	Y
Family Violence?	N	Y

Area	Response	
Adolescent History: (interview separately)		
Age at first period LMP	N	Y
# of partners?		
Sex of partners?	M	F
Any fears of partner/other violence?	N	Y
Smoker?	N	Y
Drug Use?	N	Y
Alcohol Use?	N	Y
Working?	N	Y
Do you think about hurting yourself?	N	Y
Access to gun/weapon?	N	Y
Provider:		
Date:		

Comments/Notes: