# Wills Valley Family Medicine

Name_____ Gender_____ DOB_____

Past Medical Questionnaire

Child is presently living with the following people (Check All that Applies):

_Natural Mother _Natural Father _Stepmother _Stepfather _Grandparents _Adoptive/Foster parents

Where does this child live (circle one)?: Apartment House trailer other(describe)_____

Are there any pets in the home? No_ Yes_ Are there any smokers in the home? No_ Yes_

Does your home have air conditioner? Yes No

Child's Medical history:

Child was Born: On time__ Early__ Late__ Birth weight:___lb. ___Oz.

Delivery was: Vaginal__ C/section__ Any problems during delivery? If yes please list_____

Does your child being treated for any Illness currently? If yes please list _____

Medications: Please list medicines, dosage, and how they are taken?

_____ _____

_____ _____

Family history: Has anyone in your family had any of the following problems? If so, place a check mark (✓) in the column underneath all family members who have the problem.

| problems | Mother | Father | Brother | Sister | Grand-Parents | Uncle/Aunt |
|---|---|---|---|---|---|---|
| ADHD or learning problems | | | | | | |
| Allergies | | | | | | |
| Anemia(low blood count) | | | | | | |
| Cancer(including Leukemia) | | | | | | |
| Cystic fibrosis | | | | | | |
| Diabetes | | | | | | |
| Eye problem or poor vision | | | | | | |
| Hearing problems or deafness | | | | | | |
| Heart attack that occurred <55yrs | | | | | | |
| High blood pressure | | | | | | |
| High cholesterol | | | | | | |
| Kidney/Bladder problems | | | | | | |
| Mental health problems/retardation | | | | | | |
| Migrain/headache | | | | | | |
| Seizures or Epilepsy | | | | | | |
| Stroke | | | | | | |
| Thyroid Disease | | | | | | |
| Sickle cell disease | | | | | | |