EMPOWER CHILDREN'S CLINIC
HISTORY QUESTIONNAIRE
(TO BE COMPLETED BY THE LEGAL GUARDIAN)

(Complete for all age patients)

Patient Name: ____ Date of Birth:______________________

A. Mother's Prenatal History

Number of pregnancies _______ Number of living children _______ Name of Obstetrician ___________________________
Did you have any of the following health problems during your pregnancy: Bleeding_______ High Blood Pressure ________
Surgery ______ Anemia ______ Infections ______ Accidents ______ Swelling _____ Other___________________________
____
Were any of the following used or taken during your pregnancy: Medications _______________________________________
Cigarettes ______________ Alcohol ______________ Drugs ____

B. Birth History

Where was your child born: ____________________________________ Number of weeks pregnant: __________________
Was labor induced: _______________ Hours of labor:________________ Was this a multiple birth: _____________________
Medication: ___________________________________ Type of delivery: Vaginal Forceps Cesarean
Problems or complications during labor or delivery: ____
Child's birth weight:______________________ Length: ________________________ APGAR Score: __________________
Type of feeding: Breast _______________________ Formula ____________________ Both _______________________ Did the child have problems in the hospital: Breathing ________ Color________ Feeding ________ Temperature _________ Other
____
Did the child go home with you?___________________ If no, when? __________________ Discharge weight:____________

C. Family History

Age of child's mother at delivery: __________ Father: __________ Siblings: ____
Medical History of child's parents:____
Medical problems of child's siblings: ____

Medical History of any of the relatives

D. List any past medical history that your child has

E. List any surgical history your child / Children have

F: List any hospitalizations that your child has

G: List any Emergency room visits that your child has

H. Is your child on any medication

I. Any medication allergies (If yes, state the name of the medicine and the reactions)

J: Any adverse reactions to Immunizations

List below any of child's relatives (mother, father, siblings, grandparents, aunts, uncles) who have had the following illnesses.

CONDITION	NO	YES	FAMILY MEMBER
Allergies			
Asthma/ Lung Disease			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Diabetes			
Cancer			
Anemia/Bleeding Disorders			
Seizures			
Mental Retardation /Neurological Disorders			
Liver Disease			
Kidney Disease			
Bedwetting after 10			
Hearing Impairment			
Vision Impairment			
Immune Problems			
Drug Abuse			
Alcohol Abuse			

Social History

CONDITION	NO	YES
Lives in intact home		
Siblings		
Pets		
Guns in Home		
If guns in home, are they locked up?		
Smoking		
Do you live in a house built before 1950?		
Does your child attend a school built before 1968?		
Has anyone traveled outside the country in the last year?		
Is anyone in the home in active duty military that travels outside of the country?		