Ernesto Torres, M.D.

Medical / Family History Questionnaire

Patient Name:	Date of Birth:
Form Completed By: Date	Relationship:

Pregnancy and Birth History

Name of Hospital:_____

Illnesses during pregnancy?	No	Yes
Medications during pregnancy?	No	Yes
Alcohol/Drug Abuse?	No	Yes
Problems at birth?	No	Yes

Describe:_____

Type of delivery? Vaginal C-section

Birth Weight_____Discharge Weight_____

Did baby receive Hepatitis B vaccine? No Yes

Date of Hepatitis B vaccine: _____

Newborn Hearing Screening? No Yes

Psychosocial History

Are parents working? Mother No Yes

Father No Yes

Daycare? No Yes

Other Languages? _____

Family History

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

Allergies (list) _____	No	Yes
Asthma	No	Yes
Anemia	No	Yes
Arthritis	No	Yes
Bowel/Stomach Problems	No	Yes
Cancer	No	Yes
Developmental Delay	No	Yes
Diabetes	No	Yes
Ear Infections (chronic)	No	Yes
Eczema	No	Yes
Heart Disease	No	Yes
Hepatitis/Liver Disease	No	Yes
High Blood Pressure	No	Yes
High Cholesterol	No	Yes
Kidney Disease	No	Yes
Learning Problems/ADD	No	Yes
Mental Illness	No	Yes
Migraine Headaches	No	Yes
Seizure Disorder	No	Yes
Tobacco Use	No	Yes
Tuberculosis/Lung Disease	No	Yes
Urinary Tract Infections	No	Yes

Other: _____

Medical History

Has your child ever had:

Allergies _____	No	Yes
Asthma	No	Yes
Chickenpox (Date) _____	No	Yes
Frequent Ear Infections	No	Yes
Vision/Hearing Problems	No	Yes
Skin Problems/Eczema	No	Yes
TB/Lung Disease	No	Yes
Seuzures/Epilepsy	No	Yes
High Blood Pressure	No	Yes
Heart Defects/Disease	No	Yes
Liver Disease/Hepatitis	No	Yes
Diabetes	No	Yes
Kidney Disease/Bladder Infections	No	Yes
Physical or Learning Disabilities	No	Yes
Bleeding Disorders/Hemophilia	No	Yes
Sexually Transmitted Diseases	No	Yes
Emotional or Behavioral Problems	No	Yes
Depression/Suicidal Thoughts	No	Yes
Hospitalizations/Surgeries	No	Yes
(List)_____		
Physical/Emotional/Sexual Abuse	No	Yes
Bone or Joint Injuries	No	Yes
Obesity/Eating Disorders	No	Yes
Other:_____	No	Yes

Current Medications:_____