Samuel R. Williams, M.D.

MEDICAL/FAMILY HISTORY QUESTIONNAIRE

Chart #_____

(PLEASE PRINT CLEARLY)

_____ _____ _____

Patient's Last Name First Name Middle Initial

DOB _____ SEX M ☐ F ☐

Form Completed by_____ Relationship to patient_____ Date_____

Birth History

Name of Hospital_____ State_____ Birth Wt_____ Adopted? ☐ no ☐ yes

Infant was ☐ Fullterm ☐ Premature or Postmature How many weeks old?_____ Was Hepatitis B Vaccine given? ☐ no ☐ yes ☐ not sure

Type of Delivery ☐Vaginal ☐ C-Section Feeding ☐ Breastfed ☐ Formula -which one?_____

Any Problems at birth or during pregnancy?_____

Current Household Members

Name Relationship to Patient Age Health Problems?

_____

_____

_____

_____

_____

Does anyone smoke cigarettes in the household? ☐ no ☐ yes Who? _____

Does anyone other than parent take care of child regularly? ☐ no ☐ yes Who?_____

Family History

Has anyone in the family (parents, grandparents, aunt/uncles, sisters/brothers) had:

	No	Yes	Who?		No	Yes	Who?
Asthma				Mental Disorders			
HIV/AIDS				High Blood Pressure			
Cancer				Chemical Dependency			
Diabetes				Migraine Headaches			
Heart Disease				Blood Disorder/Sickle/SC			
Learning Problems/Attention				Seizure Disorders			
Kidney Disorder				High Cholesterol			

Additional Info_____

_____

Turn over to complete

Day Care/ School

Patient ☐ stays at home ☐ private daycare ☐ home schools ☐ attends school ☐ family member provides daycare

Name of School (or Daycare)_____Grade_____
Does child attend school (or daycare) regularly? ☐ no ☐ yes
Type of class
☐ regular
☐ special class (describe)_____

Grade Failures? ☐ no ☐ yes which grade(s)_____

Additional Info:

Patient's Medical History

Any Medical Conditions or Problems ☐ none ☐ yes (please list)

_____

_____

Current Medications ☐ none ☐ yes (please list)

_____

_____

_____

Current or Previous Medical Conditions ☐ none ☐ yes (please list)

_____

_____

Hospitalizations or operations ☐ none ☐ yes (please list)

_____

_____

Allergies ☐ none ☐ yes (please list)

_____

_____