Bright Start Pediatrics
where kids shine the brightest

Medical History Questionnaire

Date:	
Patient Name:	
Preferred Name:	**Preferred Pronouns:**

Sex (circle one):	**M F** **Date of Birth:**
Form Completed By:	
Relationship to Patient:	

Child's Medical History

NEWBORNS: DO NOT COMPLETE THIS COLUMN

Allergies (Food, Medications, or Environmental):	**N**	**Y**
Acid Reflux/Heartburn:	**N**	**Y**
Anemia/Bleeding Disorder:	**N**	**Y**
Asthma/Wheezing:	**N**	**Y**
Bladder Infections/Kidney Disease:	**N**	**Y**
Broken Bones:	**N**	**Y**
Cancer:	**N**	**Y**
Chicken Pox (age):	**N**	**Y**
COVID-19 Infection:	**N**	**Y**
Dental Problems:	**N**	**Y**
Depression/Suicidal Thoughts:	**N**	**Y**
Diabetes:	**N**	**Y**
Eating Disorders (Anorexia/Bulimia):	**N**	**Y**
Emotional, Physical, or Sexual Abuse:	**N**	**Y**
Emotional/Behavioral/Psychiatric Problems:	**N**	**Y**
Ear Infections/Tubes:	**N**	**Y**
Head Injury/Concussion:	**N**	**Y**
Heart Defects, congenital:	**N**	**Y**
High Blood Pressure:	**N**	**Y**
Language Delay/Speech Problems:	**N**	**Y**
High Lead Levels:	**N**	**Y**
Learning Disabilities (ADD/ADHD):	**N**	**Y**
Liver Disease/Hepatitis:	**N**	**Y**
Migraines/Headaches:	**N**	**Y**
Mononucleosis:	**N**	**Y**
Obesity/Overweight:	**N**	**Y**
Operations:	**N**	**Y**
Physical Disabilities:	**N**	**Y**
Pneumonia:	**N**	**Y**
RSV:	**N**	**Y**
Seizures/Epilepsy:	**N**	**Y**
Skin Problems/Eczema/Hives:	**N**	**Y**
Vision Problems/Wears Glasses:	**N**	**Y**
Wetting Accidents (Day/Night):	**N**	**Y**
Specialty Doctors… Please list who your child has seen below.	**N**	**Y**

Family Medical History

Has any parent: mother (M) or father (F), maternal grandparent (MGM, MGF), paternal grandparent (PGM, PGF), aunt (A), uncle (U), sister (S), or brother (B) had:

Allergies (List):	**N**	**Y**	Who?
Asthma/Wheezing:	**N**	**Y**	Who?
TB/Lung Disease:	**N**	**Y**	Who?
Cystic Fibrosis:	**N**	**Y**	Who?
HIV/AIDS:	**N**	**Y**	Who?
Heart Disease:	**N**	**Y**	Who?
Sudden Cardiac Death:	**N**	**Y**	Who?
High Blood Pressure/Stroke:	**N**	**Y**	Who?
High Cholesterol:	**N**	**Y**	Who?
Blood Disorders:			
Anemia:	**N**	**Y**	Who?
Clotting Disorders:	**N**	**Y**	Who?
Diabetes:	**N**	**Y**	Who?
Seizures/Epilepsy:	**N**	**Y**	Who?
Mental Illness:	**N**	**Y**	Who?
Depression/Anxiety/Bipolar:	**N**	**Y**	Who?
Other:	**N**	**Y**	Who?
Cancer:	**N**	**Y**	Who?
Birth Defects:	**N**	**Y**	Who?
Hearing Loss:	**N**	**Y**	Who?
Speech Problems:	**N**	**Y**	Who?
Kidney Disease:	**N**	**Y**	Who?
Alcohol/Drug Abuse:	**N**	**Y**	Who?
Liver Disease/Hepatitis:	**N**	**Y**	Who?
Thyroid Disease:	**N**	**Y**	Who?
Learning Problems (ADD/ADHD):	**N**	**Y**	Who?
Mental Retardation:	**N**	**Y**	Who?
Family Violence	**N**	**Y**	Who?

Has any family member ever had an unexplained, unexpected death before age 50? **No** **Yes** (if yes, use below)

Reviewed By: **Date:**

(Cont.)

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Medical History Questionnaire Cont.

Pregnancy and Birth History		
Adopted:	N	Y
Prenatal Care:	N	Y
Illnesses During Pregnancy:	N	Y
Medications During Pregnancy:	N	Y
Alcohol/Drug Use During Pregnancy:	N	Y
Tobacco/Marijuana/Vaping During Pregnancy:	N	Y
Problems at Birth:	N	Y
Baby:		
Jaundice:	N	Y
Heart Murmur:	N	Y
Infection:	N	Y
Breathing Problems:	N	Y
Birth Defects:	N	Y
Other:		
Name of Hospital:		
Weeks Gestation:		
Type of Delivery - Vaginal or C-Section:		
Birth Weight:		
Newborn Hearing Screen Passed?	N	Y
Did Baby Receive Hep B Vaccine?	N	Y
Hospital Stay More Than 2 Days?	N	Y

Feeding and Digestion		
Circle One: Breast Fed Formula		
Severe Colic in first 3 months?	N	Y
Feeding Problems?	N	Y
Constipation Problems?	N	Y

Psychological History		
Who Lives in Your Household?		
Circle One: **Rent** **Own** **Shelter**		
Who Cares for Child:		
Is Child in Daycare (circle one)?	N	Y
Type (circle one): **Center** **Private Home**		
Date of Birth:		
Mother:		
Father:		
Parents: **Married** **Divorced** **Separated** (circle one)		
Parents Working:		
Mother:	N	Y
Father:	N	Y
Parents Use Tobacco:		
Mother:	N	Y
Father:	N	Y
Child Uses Tobacco (12+ years):	N	Y
Foster Care:	N	Y
Dates:		
Other Languages:		

Current Medications		
Any Current Medications?	N	Y
If yes, please list:		

Additional Information/Other Concerns

Patient Signature

I certify that the above information is accurate to the best of my knowledge.

TIME _____ ☐ AM ☐ PM **DATE** _____ Patient Signature _____

Patient is under 18 years of age or otherwise unable to consent because

TIME _____ ☐ AM ☐ PM **DATE** _____ Parent/Guardian Signature _____