

Maryland Healthy Kids Program Medical/Family History Questionnaire

Patient Name: _____		Date of Birth: _____	Sex: (circle) Male Female																																																																																																		
Form Completed By: _____	Today's Date _____	Relationship: _____																																																																																																			
PREGNANCY AND BIRTH HISTORY		PSYCHOSOCIAL HISTORY																																																																																																			
Name of Hospital: _____ Illnesses during pregnancy? No <input type="checkbox"/> Yes <input type="checkbox"/> Medications during pregnancy? No <input type="checkbox"/> Yes <input type="checkbox"/> Alcohol/Drug Abuse? No <input type="checkbox"/> Yes <input type="checkbox"/> Problems at birth? No <input type="checkbox"/> Yes <input type="checkbox"/> Describe: _____ Type of delivery? <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section Birth Weight _____ Discharge Weight _____ Did baby receive Hepatitis B vaccine? No <input type="checkbox"/> Yes <input type="checkbox"/> Date of Hepatitis B immunization: _____ Newborn Hearing Screen? No <input type="checkbox"/> Yes <input type="checkbox"/>		Who lives in household? _____ How many? _____ <input type="checkbox"/> Rent? <input type="checkbox"/> Own? <input type="checkbox"/> Shelter? Who cares for child? _____ Date of Birth? Mother _____ Father _____ Are parents working? Mother No <input type="checkbox"/> Yes <input type="checkbox"/> Father No <input type="checkbox"/> Yes <input type="checkbox"/> Foster Care? _____ Dates: _____ Other Languages? _____																																																																																																			
FAMILY HISTORY		MEDICAL HISTORY																																																																																																			
Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:		Has your child ever had:																																																																																																			
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