Patient/Family Medical Information
WESTERN COLORADO PEDIATRIC ASSOCIATES

The information in this questionnaire is an important part of your child's medical record. The information is kept confidential. Please answer each question carefully. If you need assistance, ask the nurse or doctor. We may ask you to update this information periodically. If you cannot devote attention to this questionnaire during this visit, you may complete it at another time.

Child's name: ________________________________ Birthdate: ___/____/______
MEDICAL HISTORY: Birth weight: _______ Pregnancy lasted to full term (_) or pre-term (_)—or # wks ______
Any problems at birth? (circle) Y N If yes, describe: ____
SURGERIES or HOSPITALIZATIONS (where the patient was admitted to the hospital):
At Age: _______ Reason: ____
At Age: _______ Reason: ____
At Age: _______ Reason: ____
At Age: _______ Reason: ____
Ever had bladder/kidney infection? Y N (if Y-what age? ____) Ever had wheezing? Y N (if Y-what age? ____)
Any medical problems? Y N Specify: ____
Fractures, concussion, other serious injury? Y N Specify (include age):_______________________________
ALLERGIES: No (circle) Yes (specify):____________ _________________ ______________ _______________

FAMILY HISTORY

Please place a mark or enter the information in the appropriate space regarding ***your child's relative*** *with the condition in the left-hand column.*

CONDITION	Father	Mother	Sibling	Mother's parent(s)	Father's parent(s)	Other relative (Please specify)
Allergies (hay fever, animal, etc.)						
Asthma						
Eczema						
Diabetes as a child						
Diabetes only as an adult						
Migraines						
Epilepsy or seizures						
Attention Deficit Disorder or similar disorder						
Low thyroid (hypothyroidism)						
Other thyroid (specify):						
High blood pressure						
Heart attack less than age 50 years						
Stroke less than age 50 years						
Sudden Death						
Other heart disease (specify):						
Bleeding disorder (hemophilia, etc.)						
Other blood disorder (specify):						
Breast Cancer:						
Colon Cancer:						
Other Cancer (specify type):						
Melanoma						
Leukemia or lymphoma (circle)						
Emphysema						
Other lung disease (specify):						
Lupus						
Rheumatoid arthritis						
Rheumatic fever or rheumatic heart disease						
Crohn's Disease or Ulcerative colitis (circle)						
Depression						
Schizophrenia						
Alcoholism						
Other (specify):						

FAMILY and HOME
Live in house (_) apartment (_) townhouse (_) trailer (_) other (specify) (_) _______________
Do both of the child's parents live in the home? (circle) Y N
Please list **names** of adults and relationship to the child listed above (e.g., father, mother, stepfather, etc), (ages not needed), and children (with ages) who live in the household: ___________ __________ ____________
____________ ____________ ____________ ____________ _____________
Does any member of the household smoke? (circle) Y N If "yes" inside or outside (circle)
Animals in the home (if "yes" give type of animal): (circle) Y N ____________ ____________ ____________
Heat with wood stove or fireplace? (circle) Y N Drug or alcohol problems at home? (circle) Y N