

**The Ida Karlin Healing Center for Youth
Medical/Family History Questionnaire**

Today's Date: ____ / ____ / ____

Questionnaire Completed By: _____

Relation to Patient: Self Mom Dad Stepparent Other: _____

Please mark the appropriate response

Patient Name: _____

Date of Birth: ____ / ____ / ____

PREGNANCY AND BIRTH HISTORY	PSYCHOSOCIAL HISTORY
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- 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 immunization: ____ / ____ / ____

- Who lives in household? _____
- How many? _____
- Rent Own Shelter
- Who cares for child? _____
- Date of birth: Mother: ____ / ____ / ____ Father: ____ / ____ / ____
- Are parents working? Mother: No Yes Father: No Yes
- Foster care? No Yes Dates: _____
- Other languages? _____

FAMILY HISTORY	HEALTH HISTORY
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Has anyone in the family (parents, grandparents, aunts/uncles, sisters/brothers) had:

	Who?
• TB/Lung Disease	No <input type="checkbox"/> Yes <input type="checkbox"/> _____
• HIV/AIDS	No <input type="checkbox"/> Yes <input type="checkbox"/> _____
• Suicide Attempts	No <input type="checkbox"/> Yes <input type="checkbox"/> _____
• Heart Disease	No <input type="checkbox"/> Yes <input type="checkbox"/> _____
• High Blood Pressure/Stroke	No <input type="checkbox"/> Yes <input type="checkbox"/> _____
• High Cholesterol	No <input type="checkbox"/> Yes <input type="checkbox"/> _____
• Blood Disorders/Sickle Cell	No <input type="checkbox"/> Yes <input type="checkbox"/> _____
• Diabetes	No <input type="checkbox"/> Yes <input type="checkbox"/> _____
• Convulsions	No <input type="checkbox"/> Yes <input type="checkbox"/> _____
• Allergies/Asthma	No <input type="checkbox"/> Yes <input type="checkbox"/> _____
• Mental Illness	No <input type="checkbox"/> Yes <input type="checkbox"/> _____
• Cancer	No <input type="checkbox"/> Yes <input type="checkbox"/> _____
• Birth Defects	No <input type="checkbox"/> Yes <input type="checkbox"/> _____
• Hearing/Speech Problems	No <input type="checkbox"/> Yes <input type="checkbox"/> _____
• Kidney Disease	No <input type="checkbox"/> Yes <input type="checkbox"/> _____
• Alcohol/Drug Abuse	No <input type="checkbox"/> Yes <input type="checkbox"/> _____
• Hepatitis/Liver Disease	No <input type="checkbox"/> Yes <input type="checkbox"/> _____
• Thyroid Disease	No <input type="checkbox"/> Yes <input type="checkbox"/> _____
• Learning Problems/ Attention Deficit Disorder (ADD)	No <input type="checkbox"/> Yes <input type="checkbox"/> _____
• Domestic Violence	No <input type="checkbox"/> Yes <input type="checkbox"/> _____

Other conditions/concerns: _____

Has your child ever had:

• Chicken Pox	No <input type="checkbox"/> Yes <input type="checkbox"/>
If yes, year: _____	
• Frequent Ear Infections	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Vision/Hearing Problems	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Skin Problems/Eczema	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Hypertension/High Blood Pressure	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Diabetes	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Allergies	No <input type="checkbox"/> Yes <input type="checkbox"/>
If yes, please list: _____	
• Asthma	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Lung Disease/TB	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Heart Disease/Defects	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Liver Disease/Hepatitis	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Kidney Disease/Bladder Infections	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Bleeding Disorders/Hemophilia	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Convulsions/Epilepsy	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Bone or Joint Injuries	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Hospitalizations/Surgeries	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Sexually Transmitted Diseases	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Physical or Learning Disabilities	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Obesity/Eating Disorders	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Emotional or Behavioral Problems	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Depression/Suicidal Thoughts	No <input type="checkbox"/> Yes <input type="checkbox"/>
• Abuse: Physical/Emotional/or Sexual	No <input type="checkbox"/> Yes <input type="checkbox"/>

Other conditions/concerns: _____

Please list any current medication(s): _____

Fecha de Hoy: ____ / ____ / ____

Thank you~