Pediatric Nephrology of Alabama
Medical/ Family History Questionaire

Patient Name:		Date of Birth:	Sex: (Circle) Male Female
Form Completed By	**Today's Date:**	Relationship:	

PREGNANCY AND BIRTH HISTORY

Name of Hospital: _____

Illness during Pregnancy?	No □	Yes □
Medication 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 : _____

Newborn Hearing Screen? No □ Yes □

PSYCHOSOCIAL HISTORY

Who lives in the 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? _____ Dates: _____

Other Languages?

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/ uncles, sisters/brothers) had:			Who?
Allergies (list)_____	No □	Yes □	
Asthma	No □	Yes □	
TB/Lung Disease	No □	Yes □	
HIV/AIDS	No □	Yes □	
Suicide Attempts	No □	Yes □	
Heart Disease	No □	Yes □	
High Blood Pressure	No □	Yes □	
Stroke	No □	Yes □	
High Cholesterol	No □	Yes □	
Blood Disorders/Sickle Cell	No □	Yes □	
Diabetes	No □	Yes □	
Seizures	No □	Yes □	
Mental Illness	No □	Yes □	
Cancer	No □	Yes □	
Birth Defects	No □	Yes □	
Hearing Loss	No □	Yes □	
Speech Problems	No □	Yes □	
Kidney Disease	No □	Yes □	
Alcohol/Drug Abuse	No □	Yes □	
Hepatitis/Liver Disease	No □	Yes □	
Thyroid Disease	No □	Yes □	
Learning Problems (ADD)	No □	Yes □	
Blood or Protein in urine	No □	Yes □	
Kidney Stones	No □	Yes □	
Frequent Urinary Tract Infections	No □	Yes □	
Dialysis	No □	Yes □	
Transplantation	No □	Yes □	
Other (please list)			

MEDICAL HISTORY

Has your child ever had:		
Allergies (List) _____	No □	Yes □
Asthma		
Chicken Pox (Year) _____	No □	Yes □
Frequent Ear Infections	No □	Yes □
Vision/ Hearing Problems	No □	Yes □
Skin Problems/Eczema	No □	Yes □
TB/Lung Disease	No □	Yes □
Seizures/Epilepsy	No □	Yes □
High Blood Pressure	No □	Yes □
Heart Defects/Disease	No □	Yes □
Liver Disease/Hepatitis	No □	Yes □
Diabetes	No □	Yes □
Kidney Disease/Bladder Infect	No □	Yes □
Physical or Learning Disabilities	No □	Yes □
Bleeding Disorders/Hemophilia	No □	Yes □
Sexually Transmitted Diseases	No □	Yes □
Emotional or Behaviorial Problems	No □	Yes □
Depression/Suicidal Thoughts	No □	Yes □
Hospitalizations/Surgeries	No □	Yes □
Physical/Emotional/Sexual Abuse	No □	Yes □
Bone or Joint Injuries	No □	Yes □
Obesity/ Eating Disorders	No □	Yes □
Blood or Protein in urine	No □	Yes □
Kidney Stones	No □	Yes □
Frequent Urinary Tract Infections	No □	Yes □
Dialysis	No □	Yes □
Transplantation (Year _____)	No □	Yes □
Other (please list)		