Pediatric Nephrology of Alabama

Medical/ Family History Questionaire

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

PREGNANCY AND BIRTH HISTORY

Illness during Pregnancy? No □ Yes □

Amniotic fluid Normal □ Increased □ Decreased □

Medication during Pregnancy? No □ Yes □

Alcohol/Drug Abuse? No □ Yes □

Was patient born at full term? No □ Yes □

Problems at birth? No □ Yes □

Describe: _____

Type of Delivery? Vaginal □ C-section □

Birth Weight _____ Discharge Weight _____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/ uncles, sisters/brothers) had:			Who?
Kidney disease	No □	Yes □	
Dialysis or Transplantation	No □	Yes □	
Urinary tract infections	No □	Yes □	
Blood or Protein in urine			
Kidney Stones	No □	Yes □	
Hearing loss as a young person	No □	Yes □	
High Blood Pressure	No □	Yes □	
Heart disease	No □	Yes □	
Stroke	No □	Yes □	
High Cholesterol	No □	Yes □	
Diabetes	No □	Yes □	
Birth defects	No □	Yes □	
Blood Disorders/Sickle Cell	No □	Yes □	
Asthma	No □	Yes □	
Lung disease	No □	Yes □	
HIV/AIDS	No □	Yes □	
Seizures	No □	Yes □	
Mental Illness	No □	Yes □	
Cancer	No □	Yes □	
Alcohol/Drug Abuse	No □	Yes □	
Hepatitis/Liver Disease	No □	Yes □	
Thyroid Disease	No □	Yes □	
Others (please list)	No □	Yes □	

Please list patient's current medications: (continue on reverse side)

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?

MEDICAL HISTORY

Are immunizations up-to-date	No □	Yes □
Allergies (List) _____	No □	Yes □
Has your child ever had:		
Fever without obvious cause	No □	Yes □
Weight loss/gain	No □	Yes □
Skin rash	No □	Yes □
Swelling-face, legs or stomach	No □	Yes □
Headache	No □	Yes □
Problems with vision or hearing	No □	Yes □
Frequent ear infections	No □	Yes □
Lung disease/Asthma	No □	Yes □
Heart disease/defects	No □	Yes □
Stomach problems	No □	Yes □
Liver disease/Hepatitis	No □	Yes □
Diabetes	No □	Yes □
High Blood pressure	No □	Yes □
Blood or protein in urine	No □	Yes □
Urinary tract infections	No □	Yes □
Kidney stones	No □	Yes □
Dialysis	No □	Yes □
Transplantation	No □	Yes □
Day/night urinary accidents	No □	Yes □
Physical/Learning disabilities	No □	Yes □
Bleeding dis/hemophilia	No □	Yes □
Sexually transmitted diseases	No □	Yes □
Physical/Emotional/Sexual Abuse	No □	Yes □
Emotional/Behavioral problems	No □	Yes □
Obesity/Eating disorders	No □	Yes □
Depression/Suicidal thoughts	No □	Yes □
Hospitalizations/Surgeries	No □	Yes □
Other		