Medical History Intake Questionnaire

To be completed by the parent / guardian:

Date of Last Physical Exam:_____ Examined By: _____

Name of Primary Care Provider: _____

Address and Phone Number: _____

Name of primary pharmacy:_____ Location: _____

Name / Address / Phone number of Dentist: _____

Date of Last Exam:_____ Unresolved Issues: _____

Your Child's Gender:_____ Your Child's Ethnicity / Race: _____

1. Does your child have any birth defects, handicaps, or chronic illnesses? ❑ Yes ❑ No If yes, explain:

   _____

   _____

2. Were there any issues with pregnancy? ❑ Yes ❑ No If yes, explain:

   _____

   _____

3. Was your child exposed to any prescription drugs, non-prescription drugs, or alcohol during pregnancy?
   ❑ Yes ❑ No If yes, explain:

   _____

4. Did your child have any issues sitting, standing, walking, or toilet training? ❑ Yes ❑ No If yes, explain:

   _____

   _____

5. Has your child had trouble with hay fever, eczema, or asthma? ❑ Yes ❑ No If yes, explain:

   _____

6. Does your child have allergies? (Include medication, food, seasonal, animal etc. ❑ Yes ❑ No If yes, explain including reaction:

   _____

   _____

Patient Identification – Write in or attach patient label

Name:

MRN #:

CSN #:

DOB/Sex:

KootenaiHealth

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7. Has your child had all the required immunizations? ❑ Yes ❑ No
   Date of Last Tetanus_____Last MMR_____Last Chicken Pox _____

8. Has your child received an influenza vaccine this season? (Season normally runs Sept/Oct to March/April)
   ❑ Yes ❑ No If yes, when? _____
   If no, do you consent to patient being given this season's influenza vaccine during this hospitalization if they meet criteria? (Please see attached VIS for more information about the immunization.) ❑ Yes ❑ No

   Parent/Guardian/Legal Custodian Signature: _____

9. Did your child receive the influenza vaccination last flu season? ❑ Yes ❑ No

10. Has your child ever been knocked out or had a concussion? ❑ Yes ❑ No If yes, explain:

    _____

    _____

11. Has your child ever had a heart murmur or heart trouble? ❑ Yes ❑ No If yes, explain:

    _____

12. Has your child ever had a history of urination or kidney problems? ❑ Yes ❑ No If yes, explain:

    _____

13. Has your child ever had a history of stooling or bowel problems? ❑ Yes ❑ No If yes, explain:

    _____

14. Has your child had any persistent or unusual skin rashes? ❑ Yes ❑ No If yes, explain:

    _____

15. Has your child ever had a seizure or convulsion? ❑ Yes ❑ No If yes, explain:

    _____

16. Has your child ever been hospitalized? ❑ Yes ❑ No If yes, explain:

    _____

    _____

17. Has your child had any surgeries? ❑ Yes ❑ No If yes, explain:

    _____

18. Is your child presently or recently taking any medication or pills? ❑ Yes ❑ No
    If yes, explain: (Please include prescription, over−the−counter, inhalers, topical, and / or herbal) Use table on page 3 to document.

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	Medication	Dose	Time taken	Last dose	Prescribed by	Date Started
	Example: Prozac	*20 mg*	*Every night*	*Last night*	*Dr. John*	*ex: June 2020*
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						

19. Has your child ever had any high blood pressure? ❑ Yes ❑ No If yes, explain:

_____

20. Has anyone in your family died of heart problems or sudden death before the age of 50?
❑ Yes ❑ No If yes, explain:

_____

21. Has your child had any of the medical problems such as: (Please check all that apply)
❑ Mononucleosis ❑ Tuberculosis ❑ Diabetes ❑ Hepatitis ❑ Herpes
❑ Chicken Pox ❑ HIV/AIDS ❑ Sexually Transmitted Diseases
❑ Current Communicable Diseases (i.e. Pneumonia) _____
❑ MRSA ❑ VRE ❑ Other: _____

22. Has your child had any recent issues with any of the following in the last six months: (Please check all that apply)
❑ Lice ❑ Scabies ❑ Ringworm ❑ Impetigo

23. Sleep pattern: What time does your child normally go to sleep_____Wake up_____Explain any issues with sleep: _____

24. Dietary: Does your child have any dietary aversions ❑ Yes ❑ No
If yes, explain: _____

25. Does your child have any sensory areas that staff should be aware of: _____

_____ _____

Signature of the person completing form **Date**

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