

Southern Tier Pediatrics--Patient History Questionnaire (side 2 of 2)

Child's Name: _____ Birth date: _____ Today's Date: _____

TUBERCULOSIS SCREENING

	YES	NO
Has there been any contact with an adult with active TB?	<input type="checkbox"/>	<input type="checkbox"/>
Has there been any contact with an adult at high risk for TB? (adult with HIV, incarceration/jail/prison, homelessness)	<input type="checkbox"/>	<input type="checkbox"/>
Was the patient born or has the patient traveled to countries with high rates of TB?	<input type="checkbox"/>	<input type="checkbox"/>
Has there been foreign travel by the patient as an infant?	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient been adopted from a foreign country?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a relative with a Positive TB skin test?	<input type="checkbox"/>	<input type="checkbox"/>

**IF THIS IS YOUR FIRST VISIT, OR IF THERE HAS BEEN A CHANGE,
PLEASE COMPLETE THOSE SECTION(S) IN WHICH A CHANGE HAS OCCURRED.**

FAMILY INFORMATION:

Mother's Age: _____ Occupation: _____ Highest grade attended: _____
 Father's Age: _____ Occupation: _____ Highest grade attended: _____

How many children do you have? _____ This child is child number _____.

Are any of the following illnesses or Conditions on either side of the family?
(including the patient's parents, siblings, grandparents, uncles, aunts, and cousins)

Diabetes	<input type="checkbox"/>	Mental illness	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	Substance or alcohol abuse	<input type="checkbox"/>	_____
Heart attack (before age 50)	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	Retardation	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	Deafness/blindness	<input type="checkbox"/>	_____
Hay fever	<input type="checkbox"/>	Learning disability	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	Other	<input type="checkbox"/>	_____

BIRTH AND NEWBORN HISTORY

	YES	NO
Was your Pregnancy with this child complicated in any way?	<input type="checkbox"/>	<input type="checkbox"/>
Was there any problem or complication of Labor or Delivery?	<input type="checkbox"/>	<input type="checkbox"/>
Was your child ill in any way while in the newborn nursery?	<input type="checkbox"/>	<input type="checkbox"/>
Was your child born Earlier or Later than expected?	<input type="checkbox"/>	<input type="checkbox"/>

In what hospital was your child born? _____ Birth weight? _____

Additional information: _____

