

Patient's full name: _____

Date: _____

MEDICAL & SOCIAL HISTORY

Does anyone in your family, alive or deceased, suffer from the following illnesses? If so, please state the relationship to the child, i.e. mother, sister, etc. and specific illness, i.e. hole in heart, etc.

alcoholism/drug dependency _____

hypertension _____

anemia _____

heart disease _____

arthritis _____

kidney disease _____

bleeding disorders _____

learning disorders _____

bone disease _____

lung disease _____

brain tumor _____

muscle disease _____

cancer _____

seizures _____

congenital deformities _____

skin disease _____

deafness _____

sudden infant death syndrome _____

devel. delay/intellectual disability _____

pets _____

diabetes _____

visual problems/blindness _____

emotional disorders _____

any guns in the house _____

parent's occupation _____

PEDIATRIC TUBERCULOSIS SCREENING QUESTIONNAIRE

Has your child had any contact with persons or cases of TB? Y/N

Was your child born in and or spent more than 30 days in a country other than USA? Y/N

Does your child have regular contact with adults at high risk for TB (HIV infected, homeless, incarcerated, and/or illicit drug users)?

Y/N

Does your child have HIV infection? Y/N

Y/N

Has your child had recurrent complaints in any of the following areas?

Please circle all that apply.

abdominal pain

hearing difficulties

allergies/asthma/lung disease

major stress

anxiety /depression

menstrual pain/complaints

attention/learning disorders

nasal obstruction/mouth breathing

blood in urine/stool

rapid heart beat

bone/joint/muscle pain

skin problems

chest pain/breathing difficulty

sleep disorders

difficulty with urination/bowel movements

vaginal/urethral discharge

headaches

visual problems

Has your child ever been hospitalized? Y/N

Why _____

Has your child had surgery? Y/N

Why _____

Is your child allergic to any medications?

Does your child have any other allergies?

How many children are there within your home?

Do you use city drinking water? Y/N If not, does your water source contain fluoride? Y/N

Does anyone smoke in the home or at the child's care giver's home? Y/N

Does anyone have problems with alcohol or drug abuse? Y/N

Reviewed by: _____