SOUTH CAROLINA Children's Advocacy Medical Response System

Medical Questionnaire
Ages 0 - 12

Child's Name _____ Date of Birth _____
Questionnaire filled out by _____
Relationship to child _____
Date of visit _____

Prenatal/Neonatal History (please fill out if your child is less than 3 years old):

1. How many months were you pregnant with your child? _____
2. How many weeks/months were you into the pregnancy when you made your first visit to the doctor? _____
3. Any problems during your pregnancy? ☐ Yes ☐ No
   If yes, please list _____
4. What type of delivery? ☐ Vaginal ☐ Cesarean
5. Any problems during the delivery? ☐ Yes ☐ No
   If yes, please list _____
6. Birth Weight _____ Birth Length _____
7. Any problems at the hospital nursery? ☐ Yes ☐ No
   If yes, please list _____

Medical History:

1. Has your child been diagnosed with any of these illnesses or medical conditions? *(check all that apply)*
   - ☐ Anemia
   - ☐ Asthma
   - ☐ Attention Deficit Disorder w/Hyperactivity (ADHD)
   - ☐ Chronic diarrhea
   - ☐ Chronic ear infections
   - ☐ Diabetes
   - ☐ Head injury
   - ☐ Heart murmur
   - ☐ Nasal allergies/sinusitis
   - ☐ Reflux
   - ☐ Seizures
   - ☐ Urine/bladder infection
   - ☐ Other specify_____

   ☐ **My child does not have any of these illnesses.**

2. Has your child ever been admitted to a hospital? ☐ Yes ☐ No
   If yes
   a. What was the admission for? _____
   b. How old was your child? _____
   c. Name of hospital and city _____

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3. Has your child ever had any surgeries? ☐ Yes ☐ No
   If yes
   a. What was the surgery for? _____
   b. How old was your child? _____
   c. Name of hospital and city _____

4. Does your child have any allergies to food or medications? ☐ Yes ☐ No
   If yes, please list _____
   _____
   _____

5. Are your child's immunizations up to date? ☐ Yes ☐ No
   If no, which are pending? _____

6. Please check all that apply to your child's health at this time
   - ☐ Loss of energy
   - ☐ Weight loss
   - ☐ Weight gain
   - ☐ Trouble with eyesight
   - ☐ Wears glasses
   - ☐ Difficulty hearing
   - ☐ Teeth are discolored and break easily
   - ☐ Gums bleed easily
   - ☐ Bleeds for a long time after a cut
   - ☐ Wheezing
   - ☐ Muscle aches
   - ☐ Joint pain or swelling
   - ☐ Hives
   - ☐ Eczema

   ☐ **My child does not have any of these problems.**

7. Is your child taking any medications or vitamins now? ☐ Yes ☐ No
   If yes, what is he/she taking? _____
   _____
   What illness/condition is he/she taking this for? _____
   _____

8. Who is your child's doctor? _____
   In what town/city does the doctor have his/her practice? _____

Family Medical History

Do any of your child's siblings, parents or grandparents suffer any of the following medical conditions? (Check all that apply and identify the family member affected by each illness)

- ☐ Anemia _____
- ☐ Asthma _____
- ☐ Delay in talking, moving around or understanding things _____
  _____
- ☐ Diabetes _____

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- ☐ Drug/alcohol addiction _____
- ☐ Had a lot of broken bones _____
- ☐ Had a lot of discolored, broken or chipped teeth _____
- ☐ Heart disease _____
- ☐ HIV/AIDS _____
- ☐ Loss of hearing _____
- ☐ Mental retardation _____
- ☐ Nasal allergies _____
- ☐ Nosebleeds; bruises easily _____
- ☐ Psychiatric or mental illness _____
- ☐ Seizures _____
- ☐ Does anyone in your household smoke? _____
- ☐ Other *(please list)* _____

☐ **No one in my family has any of these illnesses or problems**

Developmental History (please fill out if your child is less than 3 years old):

1. At what age did your child do the following for the first time?
   a. Roll over _____
   b. Sit up on his/her own _____
   c. Stand up _____
   d. Walk _____
   e. Run _____
   f. Clear words _____
2. Is your child already talking in phrases or sentences? ☐ Yes ☐ No
3. Is your child already toilet-trained? ☐ Yes ☐ No

Daycare / School Attendance

1. Does your child have a babysitter? ☐ Yes ☐ No
   If yes, give name and location _____
   Which days and what hours does your child spend with the babysitter? _____
   _____
2. Does your child attend a daycare center? ☐ Yes ☐ No
   If yes, give name and location _____
3. Does your child go to school? ☐ Yes ☐ No
   If yes, give the name and location _____
4. Which grade is your child in? _____
5. How is your child doing in school?
   ☐ Excellent ☐ Good ☐ Average ☐ Failing
6. If your child is failing at school, what is the problem? _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
7. Does your child attend an after-school program? ☐ Yes ☐ No
   If yes, give name and location _____

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Social History

1. Please list all adults and children currently living in same home as your child and their relationship to your child: _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
2. Has your family had any previous involvement with DSS? ☐ Yes ☐ No
   If yes, please list the year and reason for involvement: _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
3. Has your child ever been around domestic violence? ☐ Yes ☐ No

Additional Comments by Healthcare Provider:

Questionnaire reviewed by: _____ Review Date _____
Healthcare Provider