Preliminary Medical Questionnaire

Person filling out this form (Mother/Father/Others:)

1. Reason for Visiting (What would you like to consult with a doctor about your child today?)

2. Perinatal Period ※ Please circle those that apply.

While you're Pregnant: Gestational hypertension? (No / Yes : mild/severe)
Imminent miscarriage? (No/Yes : around ___months of pregnancy)
Infectious disease? (No/Yes : around _____months of pregnancy)
Taking any medications? (No/Yes : around _____months of pregnancy)

Delivery : Gestational age _____weeks _____days (Circle the one that apply.)
(Head position delivery, Breech delivery, Vaginal delivery, Forceps delivery, Suction delivery, Cesarean section (Planned / Emergent), Abnormal rotation, Premature rupture of membrane, Polyhydramnios, Meconium staining, Weak contraction, Nuchal cord)

At birth : Weight _____ g, Height _____cm, Chest circumference_____cm,
Head circumference _____cm
Hospitalization in Neonatal Intensive Care Unit or NICU : (No / Yes :
Date of Discharge Month____ Day_____)
Crying Sound (Normal / Weak), Poor Feeding (No / Yes)

3. Nutrition and Development ※ Please circle the one that applies.

Current Feeding / Nutrition (Breast feeding / Formula _____ml, ___times a day)
Solid food (Beginning stage / Middle stage / Last stage / Same food as adults),
Tube feeding (Contents) _____ml, _____times/day
Head control? ____months old, Sit up? ____months old, Pull oneself up? ___months old,
Start walking?____months old
2 to 3 words? _____months old Two-word sentence _____year old ____months

4. Past Medical History(If your child has had any illnesses, or injuries, please fill them out.)

- Infectious diseases : Measles: _____years old, Rubella: ____years old,
  Varicella (or Chickenpox): _____years old,
  Mumps:_____ years old, Others: _____years old
- Food allergies (Foods that cause allergies:)
  Drug allergies (Medications that cause allergies:)

(Please also fill in the back of the form)

5. Family Medical History

- Fill out the age and the medical history of your family members. (If your family member passed away already, please cross out that person and fill in the name of disease.)
- Circle the family members who live with you.