

# The Duke Healthy Lifestyles Program

## Medical History Form

Please complete this questionnaire and bring it with you to your clinic appointment.  
All information will be kept confidential.

Name of person filling out this form: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Home number: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Work number: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ E:mail: \_\_\_\_\_

### GOALS for a Healthier Lifestyle:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### BIRTH HISTORY:

Please describe any pregnancy complication (diabetes, medications, high blood pressure): \_\_\_\_\_

Was the delivery at  Full Term  Pre-term (early) If so, how early and why? \_\_\_\_\_

What was the birth weight? \_\_\_\_\_ Was the birth  vaginal or  C-section?

Breast fed or  bottle fed? Age at weaning: \_\_\_\_\_

Do you have any concerns about your child's development (walking, talking, etc.) \_\_\_\_\_

### MEDICAL HISTORY (of the patient): (please explain any "yes" answers)

Allergies (foods or medicines)	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Current or past medical problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Hospital stays	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Operations	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Sleep problems (snoring?)	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Headaches	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Muscle or joint pain	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Bed wetting	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Heartburn	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Constipation	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Irregular periods	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Other problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____

### MEDICATIONS (current and recent):

Drug Name	Strength (e.g. 50 mg)	How many times per day?
_____	_____	_____
_____	_____	_____
_____	_____	_____

### FAMILY HISTORY: (does anyone in the family have the following problems?)

Diabetes	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Thyroid problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Heart problems (stroke, heart attacks)	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
High Blood Pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Problems with being overweight	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Other health problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____

### SOCIAL HISTORY

Who lives at home? \_\_\_\_\_  
What school do you attend? What grade level? \_\_\_\_\_  
How is the child or adolescent doing in school? \_\_\_\_\_  
Other things you would like us to know: \_\_\_\_\_

(Over)



## CONSENT TO OBSERVE/RECORD

I/we hereby represent that I/we are the parents and/or guardian or next-of-kin of \_\_\_\_\_, a minor, and that we voluntarily give our consent to the videotaping/photographing/audio recording/interview of that child.

I/we understand that all material obtained will be used to support Duke Children's Hospital & Health Center/Healthy Lifestyles Program for educational purposes or release to public information media.

If the materials are copyrighted by Duke University, then the material will be under the control of Duke University and Duke Children's Hospital. I/we understand, however, that once materials are released to public information media – including, but not limited to television, newspaper, magazine and radio – Duke University and Duke Children's Hospital no longer has control over their use.

I/we are signing this voluntarily, and understand if I/we choose not to consent or participate, that this will in no way affect our child's eligibility to receive care through Duke University Health System.

Further, I/we understand that I/we will receive no compensation for consent to participate in this program. I/we also understand that participating in this program will not in any way affect the care our child receives, or our medical bills through Duke University Health System.

I/we have read this form and have had the opportunity to ask questions about the program. I/we agree to be bound by this consent form.

\_\_\_\_\_  
Signature of Patient

Date \_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Patient's Legal Representative (if applicable)

\_\_\_\_\_  
Relationship to Patient