Medical History Form

Date: _____

Welcome to our pediatric practice! We look forward to providing the best care for your child from birth through college. Please complete this information for our records. Thank you.

Child's Name: _____ **Date of Birth:**_____

Birth History: ☐ Boy ☐ Girl ☐ Adopted

Birth Weight:_____ Birth Hospital/State:_____

☐ Full-Term (≥37 wks) ☐ Vaginal ☐ C/Section due to _____

☐ Premature (<37 wks) # weeks____ ☐ Forceps ☐ Vacuum

Pregnancy concerns: ☐ none _____

Newborn concerns: ☐ none ☐ jaundice ☐ other_____

_____

Specialty Care:

Has your child ever seen a medical specialist? No____ Yes____

Please describe:_____

Special Interests/Hobbies/Activities:

☐ sports _____ ☐ music _____

☐ dance _____ ☐ art _____ ☐ scouts ☐ other_____

Past Medical History:

Does your child have a history of any medical conditions listed below? ☐ none

(please circle any that apply)

Genetic:	chromosome abnormality
Growth:	short stature overweight obesity
Development:	delay-speech/language delay-motor skills autism
Learning:	special education dyslexia
Behavior/Mood:	ADHD anxiety obsessive-compulsive depression
Hearing:	multiple ear infections ear tubes hearing loss
Vision:	strabismus amblyopia myopia astigmatism cataract
Speech:	delay-speech articulation stuttering speech therapy
Sleep:	snoring sleep apnea sleepwalking recurrent nightmares
Neurologic:	seizures migraines head trauma concussion
Respiratory:	seasonal allergies asthma croup RSV pneumonia
Cardiac:	heart murmur VSD ASD
Gastrointestinal:	constipation acid reflux liver disease pyloric stenosis
Urology:	bladder infections urinary reflux kidney disease enuresis
Muscle/Bone:	club foot intoeing hypotonia scoliosis physical/occupational therapy
Dermatology:	eczema acne warts molluscum hemangioma
Infectious:	multiple strep throat meningitis tuberculosis HIV
Heme/Oncology:	anemia leukemia cancer/tumor bleeding disorder clotting disorder

Other medical conditions: _____

_____

(please flip over-complete page 2)

Hospitalizations: □ none
Date_____ due to:_____
Date_____ due to:_____

Surgery: □ none
Date_____ due to:_____
Date_____ due to:_____

Current Medications: □ none

(name) (dose)

_____ _____
_____ _____
_____ _____
_____ _____

□ daily multivitamin

□ other supplements_____

Allergies: □ none known □ Latex

(name -- type of reaction)

Medication_____

Food_____

Pets_____

Seasonal_____

Indoor_____

Family Hx:

Other Children (names/ages): _____ _____

_____ _____

Please list any medical conditions of <u>family members</u>:
(ex: asthma, heart disease, high blood pressure, diabetes, obesity, cancer-type, acid reflux, lupus, arthritis, hypo/hyper-thyroid, hearing/vision problem, seizures/epilepsy, kidney problem, liver problem, melanoma, eczema, psoriasis, bleeding/clotting disorder, ADHD, depression, schizophrenia, Alzheimer's, etc.)

Mom_____
Dad_____
Sister/Brother_____
Grandparents_____
Cousins_____

Care/Education:

□@home □day care □pre-school □school grade_____ □home school □college

Home Environment:

Parents: □ married □ live together □ single-parent □ divorced □ remarried
Occupation: mom_____ dad_____
Guns: □ no □ yes -- locked away?_____
Smokers: □ no □ yes -- □ inside □ outside
Home: □ house □ apartment □ condominium
Pets: □ no □ yes -- type?_____

Please describe any specific concerns you would like to discuss regarding your child:

_____

How did you find out about our pediatric practice?

_____