

Patient Name: _____ Date of Birth _____ Age _____ Date _____

Medical History Form

This form is necessary to provide the “complete picture” of your child’s health to your provider. It includes information about the home and school/daycare environments as well as gathering information regarding all health care received outside of our office. By gathering this information, it allows your provider to offer the best care possible for your child(ren).

Please print

Social History Please Print—

| Names of: Parent’s & Sibling’s plus list others living with the child (Extended family, step-family, Grandparents... living with the child) | DOB | Relationship to Child | Lives with Child |
|--|------------|------------------------------|-------------------------|
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1. Parents Marital Status: Married Divorced Separated Never Married Other _____

2. If parents are not living together or if child does not live with parents, what is the child’s custody status?

3. Parent’s Occupation: Parent : _____ Parent: _____

4. Daytime Status: Home Daycare School

5. Does anyone in the household smoke? yes no

6. Does anyone at daycare smoke? yes no Not applicable

7. Are there pets in the home? yes no

8. Are there pets in the daycare? yes no Not applicable

9. Are there firearms in the home? yes no (If yes please check what applies)

a. They are hidden away without gun locks.

b. They are hidden away but have gun locks on them.

c. They are locked up in a gun safe or cabinet.

d. Other _____

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Patient Name: _____

Family History— (Check all that apply) Please Print

- | | | | | | | |
|--|------------------------------|------------------------------|----------------------------------|---------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Nasal Allergies | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Diabetes (before 50 years old) | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> High Blood Pressure (before 50 years old) | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Heart Disease (before 50 years old) | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Rheumatologic Disease (Arthritis, Lupus, Thyroid Disease) | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Bed-wetting (after 10 years old) | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Immune Problems | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |
| <input type="checkbox"/> Unexplained Sudden Death (before 50 years old) | <input type="checkbox"/> Mom | <input type="checkbox"/> Dad | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandmother | <input type="checkbox"/> Grandfather |

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Patient Name: _____

Birth History-- Please Print

1. Was the child adopted? Yes No (if yes answer below)
 - a. Was it an international adoption? Yes No (If yes answer below)
 - i. From what country? _____
2. Birth Weight? _____ Unknown
3. How many weeks Gestation? _____ Premature Full term Unknown
4. Was the delivery? Vaginal Cesarean
5. If cesarean, why? _____
6. Did your baby have any problems right after birth? Yes No (if yes answer below)
 - a. Explain problems _____

7. Was initial feeding? Breast? Bottle? Unknown
8. Did mother have any illness or problem with her pregnancy? Yes No (If yes answer below)
 - a. Please explain _____

9. During pregnancy, did mother?
 - a. Smoke? Yes No
 - b. Drink Alcohol? Yes No
 - c. Use drugs or medications? Yes No (If yes answer below)
 - i. Please explain _____
10. Did your baby go home with mother from the hospital? Yes No (If no answer below)
 - a. Please explain _____

Developmental History---Please Print

11. When did child?
 - a. Sit up? Normal Delayed Unknown
 - b. Walk? Normal Delayed Unknown
 - c. Speech development Normal Delayed Unknown
12. Has your child ever been evaluated for or diagnosed with a developmental delay? Yes No (If yes answer below)
 - a. Please explain _____
13. Is your child in School? Yes No (If yes answer below)
 - a. How is he/she doing in academic subjects? _____
 - b. Is he/she in special resource class? Yes No
 - c. Has he/she failed or repeated a grade? Yes No
 - d. Has he/she been diagnosed with a learning disorder? Yes No

----OVER----

Patient Name: _____

Past Medical History—Please Print

1. Please list any previous surgeries or hospitalizations?(list month/year, hospital and type of surgery) None

2. Please list any serious injuries or accidents None

3. Any drug or food allergies? Yes No (if yes list below)

a. _____

4. Does your child have, or has he/she ever had:

Chicken pox Yes No

If yes when: _____

Frequent ear infections Yes No

Problems with hearing or ears Yes No

Food or environmental allergies Yes No

Problems with eyes or vision Yes No

Asthma Yes No

Frequent bronchitis or pneumonia Yes No

Recurrent croup Yes No

Other chronic or serious lung disease Yes No

Tuberculosis or positive TB skin test Yes No

High blood pressure Yes No

High cholesterol Yes No

Heart murmur Yes No

Congenital or acquired heart defect Yes No

Anemia or bleeding problem Yes No

Blood transfusion Yes No

Frequent abdominal pain Yes No

Constipation requiring doctor visits Yes No

Bladder or kidney infection Yes No

Bed-wetting (after 5 years old) Yes No

Thyroid or other endocrine problem Yes No

Any chronic or recurrent skin problem Yes No

(acne, eczema, etc)

Frequent headaches Yes No

Convulsions or other neurologic problem Yes No

Diabetes Yes No

Cancer Yes No

HIV/AIDS Yes No

Sexually transmitted disease Yes No

Emotional disorder or suicide attempts Yes No

Behavior disorder (ADHD, ODD) Yes No

Psychiatric disorder Yes No

Use of Alcohol Yes No

For girls

Has she started her menstrual periods Yes No

Are there problems with her periods Yes No

Other Yes No

Please explain any yes answers: _____

PLEASE PROVIDE PATIENT'S IMMUNIZATION HISTORY FOR INITIAL VISIT