

NAME: _____

PAST MEDICAL HISTORY

PREVIOUS SURGERIES (list month and year, hospital, and type of surgery) _____

PREVIOUS HOSPITALIZATION (list month and year, hospital, and reason for hospitalization) _____

CHILDHOOD ILLNESSES/PROBLEMS

Has your child ever had:

mumps/measles	_____ yes	_____ no	croup	_____ yes	_____ no
chicken pox	_____ yes	_____ no	T.B./lung disease	_____ yes	_____ no
eczema/skin problems	_____ yes	_____ no	high blood pressure	_____ yes	_____ no
pneumonia	_____ yes	_____ no	kidney/bladder problems	_____ yes	_____ no
asthma/wheezing	_____ yes	_____ no	sexually transmitted disease	_____ yes	_____ no
cancer	_____ yes	_____ no	high cholesterol	_____ yes	_____ no
hepatitis	_____ yes	_____ no	handicaps/disabilities	_____ yes	_____ no
HIV/AIDS	_____ yes	_____ no	diabetes	_____ yes	_____ no
hemophilia	_____ yes	_____ no	rheumatic fever	_____ yes	_____ no
abnormal bleeding	_____ yes	_____ no	congenital heart defect	_____ yes	_____ no
allergies	_____ yes	_____ no	heart murmur	_____ yes	_____ no
frequent ear infections	_____ yes	_____ no	convulsions/epilepsy	_____ yes	_____ no
frequent colds or sore throats	_____ yes	_____ no	emotional disorders or suicide attempts	_____ yes	_____ no

Please explain any of the above _____

CURRENT MEDICATIONS (list name of drug, dose being taken, and how often it is taken. Include any vitamins or fluoride supplements) _____

DRUG OR FOOD ALLERGIES (list and describe reaction) _____

BIRTH HISTORY

Any significant prenatal complications or conditions noted before this child was born? _____

Did mother use any cigarettes, alcohol, drugs or other medications during pregnancy? _____ yes _____ no
If yes, please describe _____

DELIVERY _____ Vaginal _____ C-section

PREMATURITY (born prior to 37 weeks gestation) _____ yes _____ no
If yes, list gestation at birth _____

WEIGHT AT BIRTH _____
List any complications that occurred, such as special resuscitation, meconium at birth, need for oxygen or I.V. fluids, admission for prolonged period of time in the nursery, etc. _____

Breast fed _____ Bottle fed _____ If breast fed, approximately how long _____
Any feeding problems during first year of life (such as severe refluxing/vomiting of foods or intolerance/allergy to any formulas) _____ yes _____ no
If yes, please describe _____

(over)

DEVELOPMENTAL HISTORY

Approximate age when child first:

sat up _____ crawled _____ walked _____

put first-few words together _____

any history of learning problems _____ yes _____ no If yes, please describe _____

FAMILY HISTORY/SOCIAL HISTORY

Parents marital status _____ single _____ married _____ divorced _____ separated _____ widowed

Parents age, occupation, and any health problems

Mother _____

Father _____

Age and any health problems of other siblings NOT being seen in this office _____

List any other family member on mother (maternal) or father's (paternal) side of the family with a significant medical history (such as asthma/allergies, cancer, diabetes, bleeding problems, high blood pressure, history of early heart attacks or need for coronary bypass surgery, sudden death, kidney problems, rheumatologic diseases, or T.B./other lung diseases.)

IMMUNIZATION HISTORY (list month and year when given)

DPT/DT or DPT/Hib 1	Pneumococcal (Pneumovax)
DPT/DT or DPT/Hib 2	Influenza
DPT/DT or DPT/Hib 3	
DTaP/DT 4	
DTaP/DT 5	
OPV/IPV 1	Other Vaccinations
OPV/IPV 2	
OPV/IPV 3	
OPV/IPV 4	
Hib 1	
Hib 2	
Hib 3	
Hib 4	
Td booster	
Hepatitis B1	Tine or PPD skin test and result of test
Hepatitis B2	
Hepatitis B3	
MMR1	
MMR2	
Varicella (Chickenpox)	