Medical History Form

Patient's First/Last Name: _____ Birthdate _____

Age _____ Date _____

This form is necessary to provide the "complete picture" of your child's health to your provider. By gathering this information, it allows your provider to offer the best care possible for your child(ren).

Patient's Past Medical History—Please Print

1. Please list any previous hospitalizations? (list month/year, hospital and reason for hospitalization) □None

_____

2. Please list any previous surgeries? (list month/year, hospital and surgery performed) □None

_____

3. Please list any serious injuries or accidents? (list month/year and nature of injury/accident) □None

_____

4. Any drug or food allergies? □Yes □No (if yes list below with reaction)

_____

Please **CIRCLE** any condition your child currently has or has had in the past:

Chicken pox
If Yes When? _____
Eye conditions/corrective lenses
Frequent ear or sinus infections
Problems with ears or hearing
Frequent pharyngitis or tonsillitis
Allergic rhinitis or other allergy
Indoor allergens: _____
Outdoor allergens: _____
Asthma
Frequent bronchitis, bronchiolitis, or pneumonia
Recurrent Croup
Other chronic/serious lung disease
Tuberculosis or positive TB test
High blood pressure
High cholesterol
Heart murmur
Congenital/acquired heart defect
Anemia or bleeding problem

Blood transfusion
Frequent abdominal pain or GERD
Constipation requiring doctor visits
Bladder, kidney infection or other urologic problem
Bed-wetting (after 5 years old)
Thyroid or other endocrine problem
Diabetes
Chronic or recurrent skin problem (acne, eczema, etc)
Frequent headaches
Seizures or other neurologic problems
Developmental delay or disorder
Behavior disorder (ADHD, ODD, other)
Mental health concerns or disorder
Emotional problems or suicide attempts
Use of alcohol or drugs
Cancer
HIV/AIDS
Sexually transmitted infection
Orthopedic problem

Please explain any conditions you circled above or any other significant medical problems:

_____

Patient Name _____

Family History—Check all that apply. ONLY include GENETIC family members.

(Leave blank if the child is a foster child, adopted, or if the biological parents are unknown.)

	Mom	Dad	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Cancer								
Asthma/Other Lung Disease								
Nasal/Other Allergies								
Diabetes or Other Endocrine Problems (before 50 years old)								
High Blood Pressure								
High Cholesterol								
Heart Disease (before 50 years old)								
Rheumatologic Disease (Arthritis, Lupus, Thyroid Disease)								
Kidney Disease								
Liver Disease								
Anemia								
Bleeding Disorder								
Developmental Delay/Disorder								
Mental Illness								
Epilepsy, Convulsions, or Seizures								
Neurologic Disorder								
ADHD/ADD								
Autism								
Alcohol Abuse								
Drug Abuse								
Hearing Problems/Deafness								
Vision Impairment/Eye Disorder (not including standard glasses or contacts)								
Tuberculosis								
Bed-wetting (after 10 years old)								
Immune Problems, Recurrent Infections, or HIV/AIDS								
Milk and/or Soy Intolerance								
Other GI Disease/Disorder								
Unexplained Sudden Death (before 50 years old)								

Additional Pertinent Conditions

Explain _____

_____

Patient Name _____

Developmental History—Please Print

1. When did your child…

Sit up? ☐Normal ☐Delayed ☐Unknown **Walk?** ☐Normal ☐Delayed ☐Unknown

Speech development? ☐Normal ☐Delayed ☐Unknown

2. Has your child ever been evaluated for or diagnosed with a developmental delay? ☐Yes ☐No (if yes describe)

_____

Social History—Please Print

List the name of those LIVING IN THE HOUSEHOLD- include any parents, siblings , any extended family, step-family, grandparents, others	**Date of Birth**	**Relationship to Child**

1. Parents' Marital Status: ☐Married ☐Divorced ☐Separated ☐Never Married ☐Other

_____

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

_____

3. What is the visitation status of any non-custodial parent(s)?

_____

4. Parent's Name/Occupation: _____

Parent's Name/Occupation: _____

5. Daytime Status: ☐Home ☐Daycare ☐School

6. Does anyone in the household smoke? ☐Yes ☐No

7. Does anyone at daycare smoke? ☐Yes ☐No ☐Not applicable

8. Are there pets in the home? ☐Yes ☐No

9. Are there pets in the daycare? ☐Yes ☐No ☐Not applicable

10. Are there firearms in the home? ☐Yes ☐No

11. Are the guns locked and kept separate from ammunition? ☐Yes ☐No ☐Not applicable

Patient Name _____

Newborn history—Please Print

1. Was the child adopted? □Yes □No (if yes answer below)
   Was it an international adoption? □Yes □No If yes, from what country?_____
2. Birth Weight? _____ □Unknown
3. Child was born: □Premature □Full term □Unknown How many weeks Gestation? _____
4. Was the delivery? □Vaginal □Cesarean Reason for Cesarean _____
5. Did your baby have any problems right after birth? (CIRCLE all that apply)
   - Resuscitation at delivery
   - Required oxygen after delivery
   - Required intubation and/or assisted ventilation
   - Respiratory/breathing problems after delivery (including fast breathing that required treatment or respiratory distress syndrome)
   - Apnea (abnormally long pauses in breathing)
   - Hypoglycemia (low blood sugar)
   - Sepsis (infection) evaluation or treatment
   - Heart murmur
   - Jaundice requiring treatment
   - Hypothermia (low body temperature)
   - Delayed passage of meconium (first stool)
   - Other problem right after birth (list below)

     _____
6. Was initial feeding? □Breastmilk □Formula □Unknown
7. If a boy, was your baby circumcised? □Yes □No
8. Please CIRCLE if your child had any of the following during the newborn period.
   - Head Ultrasound
   - Examination for Retinopathy of Prematurity (ROP)
   - Abnormal newborn screen
9. Was there any routine treatment you DID NOT ACCEPT in the newborn nursery? (CIRCLE all that apply)
   - Vitamin K injection
   - Eye ointment prophylaxis
   - Hepatitis B Vaccination
   - Newborn screen
   - Hearing Screen
   - Other (please list below)

     _____

Maternal/Perinatal History—Please Print

1. Did mother have any of the following special considerations or problems with her pregnancy? (CIRCLE all that apply)
   - Assisted conception/reproduction
   - High risk pregnancy (describe)

     _____
   - Amniocentesis or CVS
   - Late, little, or no prenatal care
   - Diabetes (gestational or other)
   - Abnormal prenatal ultrasound (describe)

     _____
   - Abnormal prenatal testing (describe)

     _____
   - Other health issues for Mother or fetus (describe)

     _____
2. Did mother and/or baby experience any of the following during delivery? (CIRCLE all that apply)
   - Prolonged rupture of membranes (more than 12hrs)
   - Antibiotics required during labor
   - Induction of labor
   - Required C-section
   - Meconium at delivery
   - Other medications during delivery (list below)

     _____

     _____
3. **During** pregnancy, did mother…

   Smoke? □Yes □No Drink Alcohol? □Yes □No

   Use drugs or medications? □Yes □No If yes please list _____

PLEASE PROVIDE PATIENT'S IMMUNIZATION HISTORY FOR INITIAL VISIT