Medical History Form

For patients under 3 years old

Todays Date: ____________

Patient's First/Last Name: ______________________ **Date of Birth:** ____________

Eye Doctor: ______________________

Dentist: ______________________

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 injury/accident) ☐ NONE
   ____
4. Are there any drug or food allergies? ☐ YES ☐ NO (If yes, please list below with reaction)
   ____

Please **CHECK** any conditions 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 diseases
- ☐ 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 problems
- ☐ Bed-wetting (after 5 years old)
- ☐ Thyroid or other endocrine problems
- ☐ Diabetes
- ☐ Chronic or Recurrent skin problems (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 problems

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

____

____

____

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Patient's First/Last 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)								
High Blood Pressure								
High Cholesterol								
Heart Disease (Before 50)								
Rheumathologic Disease (Arthritis, Lupus, Thyroid Disease)								
Kidney Disease								
Liver Disease								
Anemia								
Bleeding Disorder								
Developmental Delay/Disorder								
Mental Illness								
Epilepsy, Convulsions, or Seizures								
Neurological 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)								

Additional Pertinent Conditions:

____

____

____

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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, please describe)

   ____

Social History - Please Print

List the names of those **LIVING IN THE HOUSEHOLD** - include any parents, siblings, 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 parents(s)?

   ____
4. Parents' Name/Occupation: ____
5. Parents' Name/Occupation: ____
6. Daytime Status: ☐ Home ☐ Daycare ☐ School
7. Does anyone in the household smoke ☐ YES ☐ NO
8. Does anyone at daycare smoke ☐ YES ☐ NO ☐ Not Applicable
9. Are there pets in home ☐ YES ☐ NO
10. Are there pets in the daycare ☐ YES ☐ NO ☐ Not Applicable
11. Are there firearms in the home? ☐ YES ☐ NO
12. Are the guns locked and kept separate from ammunition? ☐ YES ☐ NO ☐ Not Applicable

IN CASE OF AN EMERGENCY - PLEASE LIST CONTACT

NAME: ____________________ RELATIONSHIP: ____________________ PHONE: ____________________

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Newborn History - Please Print

1. Was your child adopted? ☐ YES ☐ NO (If yes, please answer below)
   Was this 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? (CHECK 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 treat ment or respiratory distress syndrome)
   - ☐ Apnea (abnormally long pauses in breathing)
   - ☐ Hypoglycemia (low blood sugar)
   - ☐ Sepsis (infection) evaluation or treatment
   - ☐ Heart murmur
   - ☐ Jaundice required treatment
   - ☐ Hypothermia (low body temperature)
   - ☐ Delayed passage of meconium (first stool)
   - Other problems right after birth (list below) ____________________
6. Was initial feeding? ☐ Breastmilk ☐ Formula ☐ Unknown
7. If a boy, was your baby circumcised? ☐ YES ☐ NO
8. Please CHECK 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?
   - ☐ 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? (CHECK all that apply)
   - ☐ Assisted conception/reproduction
   - ☐ High Risk Pregnancy (describe) ____________________
   - ☐ Amniocentesis or CBS
   - ☐ 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 deliver?
   - ☐ Prolonged rupture of membranes (more than 12hrs)
   - ☐ Antibiotics required during labor
   - ☐ Induction of labor
   - ☐ Required C-Section
   - ☐ Meconium at delivery
   - ☐ Other medications during delivery(please 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

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