PAST MEDICAL HISTORY FORM (2 MONTHS AND OLDER)

Child's name | Birth date | Nick Name /Preferred Name

Previous pediatrician | City and State

Referred by

Mother's name | Occupation | Age

Father's name | Occupation | Age

Sibling's name | Medical problems | Age

Sibling's name | Medical problems | Age

Sibling's name | Medical problems | Age

Parent's marital status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Other

Who does the child live with?

Does anyone in the home smoke cigarettes, drink alcohol or use street drugs?

Does your family or the child observe any special diets?

Any religious / spiritual affiliations?

What daycare/school does your child attend?

Any concerns at school or daycare (learning or behavior)?

Any hobbies or sports?

CHILD'S MEDICAL HISTORY:

Hospital of delivery: | Vaginal delivery or C-section?

Birth weight: | Gestational Age (number of weeks):

Complications at birth?

Allergies:

Current meds:

Hospitalizations: (reason and date)

Surgery including circumcision: (type and date)

Immunizations up to date? (please give immunization to medical assistant)

Current Medical Conditions or Concerns:

CHILD'S MEDICAL HISTORY: Has your child ever had or been treated for the following:

Allergies, sinus	☐ Yes ☐ No	Food allergy/intolerance	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Wheezing, asthma, bronchitis	☐ Yes ☐ No
Behavior problems/ADHD	☐ Yes ☐ No	Eczema or skin problems	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No	Heart problems	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Hepatitis or liver problems	☐ Yes ☐ No
Bowel problems	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Thyroid problems	☐ Yes ☐ No	Kidney problems	☐ Yes ☐ No
Depression / psychiatric	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Chicken pox	☐ Yes ☐ No Date:		
Positive PPD/TB test	☐ Yes ☐ No Date:		

FAMILY HISTORY:
Has anyone in the family ever had or been treated for the following? (Include the child's siblings, mother, father, grandparents, aunts and uncles.)

Allergies, sinus	☐ Yes ☐ No	Food allergy/intolerance	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Wheezing, asthma, bronchitis	☐ Yes ☐ No
Positive PPD/TB	☐ Yes ☐ No	Eczema or skin problems	☐ Yes ☐ No
High blood pressure	☐ Yes ☐ No	Heart problems	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Hepatitis or liver problems	☐ Yes ☐ No
Bowel problems	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Thyroid problems	☐ Yes ☐ No	Kidney problems	☐ Yes ☐ No
Depression / psychiatric	☐ Yes ☐ No	Drug or alcohol problems	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Cancer	☐ Yes ☐ No		