# Patient Medical History

**Date:** _____

**Patient Name:** _____ **Date of Birth:** _____

**Allergies:** (Include Drug, Reaction, and Age of Onset):

_____

_____

_____

Has your child had allergic reactions to any medications, food, insect bites? Yes No
Which ones? _____
Has your child had reactions to any Immunizations? ? Yes No
Which ones? _____
Any hospitalizations other than for birth? ? Yes No
For what? _____
Any Serious Injuries? ? Yes No
What kind? _____
Are there any medications taken regularly? ? Yes No
Which ones? _____

**Current Problems:**

_____

_____ _____

**Birth History:**

Birth Length: _____
Discharge Weight: _____
Duration of Labor:

Did the mother take any medications other than Vitamins and Iron? Yes No

Birth Weight: _____
Gestational Age at Birth (weeks): _____
Did the mother have any illness during pregnancy? Yes No

Did the baby have any trouble while in the hospital? (Jaundice, infections, other?) Yes No What kind? _____

Birth Head Circumference: _____
Delivery Method: Vaginal C-Section
If C-Section, why? _____

Infant Feeding: Breast Bottle Both
Formula Name? _____

APGAR 1m: _____ APGAR 5m: _____ APGAR 10m: _____

Newborn Hearing Screening: Pass Fail, Other Comments:

_____

Where has your child gone for check-up until now?

_____

Date of last check-up: _____ Date of last dental check-up:

_____

**Medical History:** (Check Appropriate Box and Comment in Margins)

| | | |
|---|---|---|
| ADD/ADHD_____ | Yes | No |
| Anemia _____ | Yes | No |
| Congenital Heart Disease_____ | Yes | No |
| Developmental delay _____ | Yes | No |
| Eczema _____ | Yes | No |
| GE Reflux _____ | Yes | No |
| Murmur _____ | Yes | No |
| Recurrent Otitis (ear infections) ___ | Yes | No |
| Seizures _____ | Yes | No |
| UTI _____ | Yes | No |
| Vesicoureteral Reflux _____ | Yes | No |
| Pneumonia _____ | Yes | No |

| | | |
|---|---|---|
| Allergic Rhinitis _____ | Yes | No |
| Asthma _____ | Yes | No |
| Constipation _____ | Yes | No |
| Diabetes _____ | Yes | No |
| Food Allergies _____ | Yes | No |
| Mental Illness _____ | Yes | No |
| Prematurity _____ | Yes | No |
| Recurrent Strep Throat _____ | Yes | No |
| Substance Abuse _____ | Yes | No |
| Vision Problems _____ | Yes | No |
| Wheezing _____ | Yes | No |
| Is your child's appetite usually good? _____ | Yes | No |
| Is it good now?_____ | Yes | No |

Patient Name: _____

Date of Birth: _____

Other Medical History:

_____

_____

_____

Was there severe colic or any unusual feeding problem during the first 3 months? □ Yes □ No
Do any foods disagree with him/her? □ Yes □ No
Does he/she take vitamins? □ Yes □ No
Does he/she have any problems with diarrhea? □ Yes □ No

**Surgical History:** (Check Appropriate Box)

| | | | Date | Surgeon |
|---|---|---|---|---|
| Adenoidectomy (adenoids removal) | Yes | No | | |
| appendectomy (appendix removal) | Yes | No | | |
| Ear Tubes | Yes | No | | |
| Fundoplication | Yes | No | | |
| Gastrostomy Tube Placement | Yes | No | | |
| Heart Surgery | Yes | No | | |
| Hernia Repair | Yes | No | | |
| Orthopedic Surgery | Yes | No | | |
| Tonsillectomy | Yes | No | | |
| Urologic Surgery | Yes | No | | |
| VP Shunt | Yes | No | | |

Other Surgical History:

_____

_____

Please list any other medical problems:

_____

_____

**Family History:** (Check all boxes that apply)

| Relationship to CHILD | | Name | A:Alive | D:Deceased | ADD/ADHD | Allergies | Anemia | Asthma | Cancer | Diabetes | Eye Disease | GI Problems | Heart Disease | High Cholesterol | Hypertension | Kidney Disease | Mental Illness | Migraines | Seizures | Substance Abuse | Thyroid Disease | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Parents** | Mother | | A | D | | | | | | | | | | | | | | | | | | |
| | Father | | A | D | | | | | | | | | | | | | | | | | | |
| **Sibs** | Sister | | A | D | | | | | | | | | | | | | | | | | | |
| | Brother | | A | D | | | | | | | | | | | | | | | | | | |
| **Aunts/ Uncles** | *M Aunt | | A | D | | | | | | | | | | | | | | | | | | |
| | *M Uncle | | A | D | | | | | | | | | | | | | | | | | | |
| | *P Aunt | | A | D | | | | | | | | | | | | | | | | | | |
| | *P Uncle | | A | D | | | | | | | | | | | | | | | | | | |
| **Grand-parents** | *MGM | | A | D | | | | | | | | | | | | | | | | | | |
| | *MGF | | A | D | | | | | | | | | | | | | | | | | | |
| | *PGM | | A | D | | | | | | | | | | | | | | | | | | |
| | *PGF | | A | D | | | | | | | | | | | | | | | | | | |

Patient Name: _____

Date of Birth: _____

Comments (including other family medical problems):

_____

_____

_____

_____

*M=Maternal, the patient's mother's side of the family
*P=Paternal, the patient's father's side of the family

Additional Family History, including other siblings, may be added below:

| Relationship to CHILD | Name | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A | D | | | | | | | | | | | | | | | | | | |
| | | A | D | | | | | | | | | | | | | | | | | | |
| | | A | D | | | | | | | | | | | | | | | | | | |
| | | A | D | | | | | | | | | | | | | | | | | | |
| | | A | D | | | | | | | | | | | | | | | | | | |
| | | A | D | | | | | | | | | | | | | | | | | | |
| | | A | D | | | | | | | | | | | | | | | | | | |

**Home Environment:**

Number of People at Home: _____

Lives with biological parents: Yes No

Foster Care: Yes No

Primary Care Givers (circle): Parents Daycare Relatives Others: _____

Daycare (hours/day): _____

Time at Relatives (hours/day): _____

Pets: Yes No

**Parent's Status:**

Parent's Marital Status (circle): Married Divorced Single Other_____

Mother's Occupation: _____

Father's Occupation: _____