Pediatrics & Adolescent Medicine, PA

Patient Medical History

NAME ____________________ BIRTHDATE ____________________

PATIENT HISTORY

Where was the child born? ____________________ Obstetrician ____________________

Is child adopted? ____________ Race ____________ At what age? ____________ Is child aware? ____________

Full term pregnancy? ____________ Premature? ____________ Type of delivery? ____________

Mother: Have you had breast surgery? ____________________

Did you take hormones or medicines during pregnancy? ____________________

Do you or the father have any history of S.T.D. (herpes, HIV, group B strep, etc.)? ____________________

Problems at birth or in first few weeks? ____________________

Birth wt. ____________ Length ____________ Head Circ. ____________ Apgar ____________

Breast/bottle fed ____________ Sat alone ________ mos. Walked ________ mos. Words ________ mos.

Sentence ________ mos. First teeth ________ mos. Bladder ________ mos. Bowel ________ mos.

Is your child taking medication now? ____________________

PATIENT'S PAST MEDICAL/SOCIAL HISTORY

Rubella (German measles) ____________________

Chicken pox Disease ____________ Vaccine ____________

Strep Throats ____________ Ear infections ____________

Pneumonia ____________________

Convulsions/Seizures ____________________

Urinary infections ________ Bedwetting/soiling problem? ________

Asthma ____________________

Allergic to any medication? ____________________

Allergic to any food or insects? ____________________

Any smokers at home? ____________ Any pets? ____________

Is he/she receiving desensitization shots? ____________________

Heart disease? ________ A heart murmur? ____________

Meningitis? ____________________

Has child received blood transfusion or blood products? ____________

Any orthopedic (bone, joint, muscle) problems? ____________

School Problems/Performance:

Scholastic ____________________

Conduct ____________________

Has child had a learning problem? ____________________

Has child ever been in a special class? ____________________

Handicaps? ____________________

Any other past illness? ____________________

OPERATIONS (Enter Dates)

Circumcision ____________________

Tonsils and Adenoids ____________________

Appendectomy ____________________

Ear Tubes ____________________

Other operation or hospitalizations ____________________

FAMILY HISTORY

	BIRTH DATE	HT.	WT.	MEDICAL PROBLEMS	EDUCATION LEVEL
MOTHER					
FATHER					

Any history in close relative (grandparent, sibling, aunt, uncle) of: (*please check appropriate items)*

__ Interrupted Pregnancies __ HIV/AIDS __ Birth Defects __ Kidney Disease __ Substance Abuse
__ Tuberculosis __ Diabetes __ Chemotherapy __ Thyroid Disease __ Other
__ Allergies __ High Cholesterol __ Bleeding Tendencies __ Liver Disease
__ Convulsions or Epilepsy __ High Blood Pressure __ Sudden Unexpected Death or fatality from illness __ Mental or Emotional Problems
__ Other Heart Disease __ Early Heart Attacks __ Cancer

Has there been a separation, divorce or death? ____________________ When? ____________________

Who is legal guardian? ____________________ With whom does child live? ____________________

Has there been a remarriage? ____________ What has been the attitude of your child to the situation? ____________________