Medical History

Patient's Name: ___________________________________ **Patient's Date of Birth:** ___________

What is the reason for today's visit: [ ] General Check-up [ ] Vaccines [ ] School Physical [ ] Sports Physical [ ] Asma [ ] Developmental problem [ ] Sickness:____

Name of Previous Physician: ________________________Telephone #: ___________________

Physician Address:____

Pharmacy (Name/Address/Telephone#)____

Allergies: [ ] Penicillin [ ] Eggs [ ] Milk [ ] Sea Food [ ] Bees/Wasps [ ] Latex [ ] Animals____ [ ] Peanuts [ ] Indoor Allergens[ ] Outdoor Allergens [ ] Other______________

Is the patient currently taking any medications? Please list them:____

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Past Medical History

[ ] Hospitalizations (reason, year)_________________________ [ ] Surgeries (type, year)____________________________
[ ] Chickenpox (age, year)_______________________________ [ ] Asthmatic(age)_________________________________
[ ] Heart Problems (age)_________________________________ [ ] Anemia (age)___________________________________

Family Medical History: *Please indicate relationship of family member to patient who has the following history.*

[ ] Nasal Allergies: _____________ [ ]Asthma/Lung disease _____________ [ ] Tuberculosis ______________
[ ] Heart Condition:____________] High Blood Pressure _____________[ ] High Cholesterol _____________
[ ] Diabetes _____________ [ ] Cancer ______________ [ ] Anemia ______________
[ ] Mental Retardation or Developmental Problems ______________ [ ] Psychological Illness ______________

Social History: *This information is confidential and use to provide the best treatment for the patient.*

[ ] Smokers in the Home (specify who)______________ [ ] Pets in the home (specify type)__________________

Birth Information

Gestational Age:
[ ] Full Term [ ] 36 Weeks [ ] 35 Weeks [ ] 34 Weeks [ ] 33 Weeks [ ] 32 Weeks [ ] 31 Weeks [ ] 30 Weeks

Type of Delivery: [ ] Normal (vaginal) [ ] C-Section **Feeding:** [ ] Bottle [ ] Breast [ ] Both

Birth Measurements: Length________________inches Weight________pounds__________ounces

Any complications with pregnancy for this patient? ____

To the best of knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if the patient has a change in this information.

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Signature of parent, guardian or parent **Date**

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Print name of parent, guardian, or parent **Date**

Medical History Cont...

[ ] Taking any medication, vitamins or herbal supplements (specify)____________________________

[ ] Constipation requiring Dr. visits [ ] Bladder or kidney infections [ ] Ears/Hearing Problems______

[ ] Chronic or recurrent skin problems (ance, eczema, etc.)_____________ [ ] Seizures

[ ] Diabetes [ ] Thyroid Problems [ ] Orthopedic problems (specify)__________________________

[ ] Eye conditions/Corrective Lenses (specify)______________ [ ] Menstrual period (age)_________

[ ] Any problems with menstruation (specify)______________ [ ] Other significant health problems

Social History Cont:
[ ] Lives with intact family [ ] Non-intact Custody status (specify)_______ [ ] Siblings_________

[ ] Guns in the home (if yes, are they locked and kept separate from ammunition?)_______________________

Newborn History:
[ ] Resuscitation at delivery [ ] Hypoglycemia [ ] Hypothermia [ ] Sepsis Screening Labs [ ] Jaundice

[ ] Transcutaneous Bilirubin [ ] Circumcision [ ] Delayed passage of meconium [ ] Murmur

[ ] Respiratory problems (specify)_______________ [ ] Oxygen [ ] Assisted ventilation [ ] Apnea

[ ] Head ultrasound [ ] Ophthalmologic exam

Maternal Perinatal History:
[ ] Assisted conception [ ] High risk pregnancy [ ] Amniocentesis/CVS [ ] Absence of prenatal care

[ ] Use of alcohol [ ] Use of drugs (specify)_______[ ] Problems w/ maternal health________________

[ ] Problems w/ fetus__________ [ ] Induction of labor [ ] Prolonged rupture of membranes

[ ] Antibiotics during labor (specify type)____________[ ] Other medication during labor___________