



Medical History Form

Date: _____

Welcome to our pediatric practice!!! We look forward to providing the best care for your child over the years ahead. Please complete this information for our records. Thank you.

Child's Name: _____ **Date of Birth:** _____

Birth History:

Birth Weight: _____ Full-Term Premature, # weeks: _____ Boy Girl

Vaginal C/Section, C/Section due to: _____

Hospital Name/State: _____

Pregnancy concerns? No Yes (Please explain): _____

Any medical problems with your newborn after delivery? No Yes

Please describe any newborn problems: _____

Specialty Care:

Has your child ever seen a medical specialist? No Yes (Please explain):

Past Medical History:

Does your child have a history of any medical conditions? No Yes (please circle any that apply)

Genetic: chromosome abnormality

Neurologic: seizures migraines head trauma concussion Other: _____

Respiratory: asthma croup BPD pneumonia seasonal allergies Other: _____

Cardiac: heart murmur VSD ASD Other: _____

Gastrointestinal: constipation acid reflux liver disease pyloric stenosis Other: _____

Urology: urinary tract infections urinary reflux kidney disease enuresis Other: _____

Muscle/Bone: club foot hypotonia scoliosis Other: _____

Dermatology: eczema acne warts molluscum hemangioma Other: _____

Infectious: tuberculosis HIV meningitis ear infections strep throat Other: _____

Heme/Onc: anemia leukemia cancer Other: _____

Behavior/Mood: ADHD anxiety obsessive-compulsive depression Other: _____

Development: delay-speech / language delay-motor skills autism Other: _____

Learning: special education dyslexia Other: _____

Speech: articulation / speech therapy Other: _____

Hearing: ear tubes hearing loss Other: _____

Vision: strabismus amblyopia myopia astigmatism cataract Other: _____]

Additional Details: _____

Hospitalizations: none

Date: _____ due to: _____

Date: _____ due to: _____

Surgeries: none

Date: _____ due to: _____

Date: _____ due to: _____

Current Medications: none

(name) _____ (dose) _____

Allergies: none known

(name & reaction)

Medication: _____

Food: _____

Pets: _____

Seasonal: _____

Indoor: _____

Latex: _____

Family History:

Other Children (names/ages):

Please list any family medical conditions:

Mom: _____

Dad: _____

Sister/Brother: _____

Grandparents: _____

Cousins: _____

Care/Education:

home day care pre-school school-grade _____ home school college

Home Environment:

Parents: married single / live together single-parent divorced

Guns: no yes -- locked away? _____

Smokers: no yes -- inside outside

Home Type: house apartment

Pets: no yes -- type? _____

Please describe any other specific concerns you would like to discuss regarding your child:

How did you find out about our pediatric practice?
