Royale Pediatric Healthcare, PC

MEDICAL & FAMILY HISTORY

PATIENT'S NAME	GENDER	FORM COMPLETED BY ____________________
DATE OF BIRTH		RELATIONSHIP TO PATIENT __________________

PREVIOUS PEDIATRICIAN

PREGNANY & BIRTH

Mother's age at pregnancy: ____________

Any illness during pregnancy: NO YES: _____________

Medications during pregnancy: NO YES: _____________

Smoking/Alcohol/Drug Use during pregnancy? NO YES

Baby born on time? EARLY LATE ON TIME/FULL TERM

Type of Delivery: **Vaginal** **C-Section**

Reason for C-Section: __________________________________

Birth Complications: NO YES: ____________________

Problems with baby at birth? Breathing Jaundice Other

Problems after birth? NO YES: ____________________

PAST MEDICAL HISTORY

Allergic Reactions: NONE FOOD MEDICINE ANIMALS

Current Medications: NONE IF YES, LIST BELOW

MED 1) ____

MED 2) ____

MED 3) ____

Immunizations up to date: NO YES UNSURE

Do you have an immunization record? NO YES

Any serious injuries or hospitalizations? NO YES

If Yes, please provide details: ______________________________

Please indicate if your child has any history of the following:

CONDITION	N	Y	CONDITION	N	Y
German Measles (Rubella)			Rheumatic Fever		
Problems with hearing/vision			Seizures		
Strep throat			Joint Problems		
Measles/Mumps			Whooping Cough		
Feeding/nutritional deficiency			Ear Infections		
Chicken Pox			Eczema/Hives		
Sickle cell anemia			Hepatitis		
Asthma/Wheezing			Urinary Infections		
Anemia			Developmental delays		
Bleeding Tendency			Mental/behavioral		
Blood Transfusions			Other:		

FAMILY MEDICAL HISTORY

Please indicate if the patient's first degree relatives – Mother (M), Father (F), Siblings (S), Grandparent (G) Other Family Member (O) have the following conditions. If no first degree relatives have the condition, check the box for "NO" if you unsure of your family's medical history, check the box for "U" indicating unsure.

CONDITION	NO	M	F	G	S	O	U
Anemia/Blood disorder:							
Asthma:							
Intellectual disability:							
Drug/Substance Abuse:							
Alcoholism:							
HIV/AIDS:							
Cystic Fibrosis:							
Muscular Dystrophy:							
Tuberculosis:							
Epilepsy/Seizures:							
Heart Disease:							
High Blood Pressure:							
High Cholesterol:							
Diabetes (I or II) :							
Migraine:							
Sudden Infant Death:							
Birth Defects:							
Cancer :							
Early Blindness/ Deafness:							
Mental/behavioral health:							
Sickle Cell Anemia:							
Thyroid Issues:							

FEEDING & NUTRITION

Food Allergies ________________________

Appetite: Normal Under Eating Over Eating

Colic or feeding problems during first 3 months? Yes No

Breast fed? No Yes, Number of months ___________

Formula? No Yes, Current Brand _______________

Vitamins? No Yes, Current Brand _______________

Special Diet? No Yes _____________________

MEDICAL & FAMILY HISTORY

FAMILY PROFILE

Parent Marital Status:

Married

Separated

Divorced

Single/never married

Living Situation:

Home/Apartment

Shelter

Other: ________________

Do you speak a language other than English at home?

Yes

No

Other Language(s) spoken:

____

What is the child's living situation?

Lives in two parent household (biological or adoptive parents)

Lives in single parent (biological or adoptive parent)

Joint custody (splits time between two households)

Lives with foster family

Lives with guardian(s)

Lives in shelter

Other (please describe):

Child's Siblings:

None: **Yes, listed below:**

Name: ______________________ **Age:** ____

Name: ______________________ **Age:** ____

Name: ______________________ **Age:** ____

Name: ______________________ **Age:** ____

Name: ______________________ **Age:** ____

Parent 1: ____________________________

Age: ____________

Highest level of education:

High School **Other**

College

Advanced Degree

Occupation: ______________________

Parent 2: ____________________________

Age: ____________

Highest level of education:

High School **Other**

College

Advanced Degree

Occupation: ______________________

DEVELOPMENT & BEHAVIOR

Age at which child: Sat alone _______ Walked ________ Used Sentences ________

Grade in school: ____________________

Problems in school? Yes No

Learning problems? Yes No

Getting along with other children? Yes No

Behavior problems? Yes No

Bedwetting? Yes No

Sleeping Issues? Yes No

Hobbies (Please list): ____

(For girls) age of first period: ______________

SOCIAL HISTORY

Any family/patient concerns with:

Finances: Yes No

Employment: Yes No

Education/Employment: Yes No

Physical Activity: Yes No

Alcohol/Drug use: Yes No

Housing: Yes No

Access to food: Yes No

Transportation: Yes No

Domestic abuse/violence: Yes No

PREFERRED PHARMACY:

Name: ____

Phone Number: ______________________________ Fax Number: ______________________________

Address: ____