MEDICAL & FAMILY HISTORY

PATIENT'S NAME | **DATE OF BIRTH** | FORM **COMPLETED BY** _____

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			Rheumatic Fever		
Problems with hearing/vision			Seizures		
Strep throat			Joint Problems		
Red Measles			Whooping Cough		
Mumps			Ear Infections		
Chicken Pox			Eczema/Hives		
Scarlet Fever			Hepatitis		
Asthma/Wheezing			Urinary Infections		
Anemia			Other:		
Bleeding Tendency					
Blood Transfusions					

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:							
Mental Retardation:							
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:							
Cancer:							
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

What is the child's living situation?

☐ Lives in two parent household (biological)

☐ Lives in two parent household (biological & non-biological)

☐ Lives with adoptive parents

☐ Joint custody (splits time between two households)

☐ Single custody (lives with one parent)

☐ Lives with foster family

☐ Lives with guardian

Parent 1:

Age: _____

Highest level of education:

☐ High School

☐ College

☐ Advanced Degree

Occupation: _____

Parent 2:

Age: _____

Highest level of education:

☐ High School

☐ 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: _____