Medical History Form

Informant: Mother Father Other:_________________________ Medical Assistant:____________________________

PATIENT NAME:____ PATIENT DOB: _________________

PLACE OF BIRTH:_____________________________________ BIRTH WEIGHT:_________________ BIRTH HEIGHT:__________

BIRTH HISTORY: VAGINAL C-SECTION PRE-TERM FULL-TERM POST-TERM ___________WEEK GESTATION

OBSTETRICIAN:____

WERE THERE ANY COMPLICATIONS AT BIRTH? NO YES IF C-SECTION, WHY?___________________________________

DID YOUR INFANT HAVE ANY OF THE FOLLOWING CONDITIONS AT BIRTH?

*Jaundice requiring phototherapy *Respiratory Distress requiring oxygen/mechanical ventilation
*Heart murmur requiring evaluation *Abnormal Ultrasound
*Fever/Infection *Passed /Failed Hearing Test

LIST ANY OTHER COMPLICATIONS NOT MENTIONED ABOVE DURING PREGNANCY OR BIRTH:
____
____
____

DOES YOUR CHILD HAVE ANY ALLERGIES? YES NO IF YES, PLEASE NAME THE ALLERGY ___________________________________
____

WHAT TYPE OF REACTION? ____
____
____

CURRENT MEDICATIONS:____

PREVIOUS MEDICATIONS:____

HOSPITALIZATIONS: Has your child ever been hospitalized for any reason? YES NO

Date	Reason
____________	____
____________	____
____________	____

SURGERIES: Has your child ever had any surgeries? YES NO

Date	Surgeon	Type of Surgery
____________	_____________________	______________________________
____________	_____________________	______________________________
____________	_____________________	______________________________

Was there any negative reaction to anesthesia? YES NO

OVER

List any major accidents involving your child: ____

List any other physicians that care for your child: ____
____

Has your child ever had any of the following conditions? (Circle All That Apply)

Headaches	Visual Disturbance	Seasonal Allergies	Ear Infection(s)
Nosebleeds	Chronic Cough	Heart Murmur	Broken bones(s)
Breathing Problems	Kidney Problems	Urinary Tract Infection	Severe Dry Skin
Seizures	Diabetes	Behavior/Mood Disorder	Bedwetting
Constipation	Bleeding Tendency	Sickle Cell Anemia	Blood Disorder

Please explain any item circled above:
____
____
____

Was/Is your child: Bottle-fed Breast-fed How long? ____

Does/did your child use a pacifier? YES NO How long? ____

Does your child attend daycare? YES NO How long? ____

How many children attend your child's daycare? 0-5 6-10 11-15 More than 15

Does anyone in your household smoke cigarettes? YES NO Does caregiver smoke? YES NO

Are there any pets in your home? YES NO What type? Dog Cat Other: __________________________

Members of Household: Mom Dad Siblings (# ______) Other: ____

Has anyone in your family ever been diagnosed with any of the following conditions? (Circle all that apply)

Asthma	Allergic Rhinitis	Heart Disease	High Blood Pressure
High Cholesterol	Kidney Disease	Cancer	Stroke
Diabetes	Inflammatory Bowel Disease	Ulcers	Migraine Headaches
Sickle Cell Anemia	Other Anemia	Hepatitis	Gallstones
Kidney Stones	Thyroid Disease	Depression/Mental Illness	

Please explain any items circled above:
____
____
____
____
____
____