Completed by_____(Clinic Use) 2/7

Medical History

PATIENT'S BIRTH HISTORY

Mother's prenatal history:

Name: _____ Date of Birth: _____

Name of OB_____Number of pregnancies_____Number of living children ____

During pregnancy/immediately around the time of delivery, were there any maternal health issues? ☐ Yes ☐ No (*if yes, see below)

During pregnancy, did mother use prenatal vitamins? ☐ Yes ☐ No

During pregnancy, did mother take any prescribed medications? ☐ Yes ☐ No (*if yes, see below)

drink alcohol? ☐ Yes ☐ No (*if yes, see below)

use tobacco? ☐ Yes ☐ No (*if yes, see below)

use other drugs? ☐ Yes ☐ No (*if yes, see below)

Please provide details / explain yes answers from above:

_____

Delivery:

Hospital of Birth _____

Type of Birth ☐ VAGINAL (& if needed, additional comments, ie-vacuum-assist) _____

☐ CESAREAN Reason: _____

Gestational age at delivery ☐ Early (< 37 weeks: what gestational age?_____) ☐ Term (37-42 weeks) ☐ Late (> 42 weeks)

Birth Weight_____Length_____Head Circumference _____

Discharge weight _____ Apgar Score _____

Was infant discharged at same time as mother? ☐ Yes ☐ No If not, when? ____

_____ Initial feeding ☐ Breast (How long?____(wks/mos)

☐ Formula (Type:_____) Was Hepatitis B vaccine given? ☐ Yes ☐ No If yes, what date was vaccine given?__☐ Date not known Passed hearing screen? ☐ Yes ☐ No ☐ Not done ☐ Unsure

Did infant have problems at/right after birth? ☐ Yes ☐ No *If yes, please see the following:*

Did your infant have an ICU stay? ☐ Yes ☐ No

Problems included ☐ breathing ☐ temperature ☐ feeding ☐ blood sugar ☐ jaundice ☐ other_____

GENERAL PATIENT HISTORY

Are your child's immunizations up to date? ☐ Yes ☐ No

Please list any medications your child is taking (include dosage/frequency, any other pertinent information (ie-how long your child has been on medication/reason for taking medication)

_____

_____

Does your child have any serious medical conditions? ☐ Yes ☐ No

Has your child had previous hospitalizations? ☐ Yes ☐ No

Has your child had previous surgeries? ☐ Yes ☐ No

Does your child see any specialists? ☐ Yes ☐ No

Has your child had any ER visits in the past year? ☐ Yes ☐ No

Has your child had adverse reactions to immunizations? ☐ Yes ☐ No

Please explain yes answers from above:

_____

_____

_____

_____

_____

☐ Unknown past medical history If adopted, at what age? _____

HOUSEHOLD

Please list who lives in the child's home ____

Please list siblings who do not live at home _

If one or both parents do not live in the home, how often does the child see the parent(s) not in the home?

_____

Are there pets at home? ☐ Yes ☐ No If yes, how many and what kind are they? _____

Does your child attend daycare or school? ☐ Yes ☐ No Does your child have exposure to any smokers? ☐ Yes ☐ No

Parental status ☐ married ☐ separated ☐ together but not married

☐ divorced/joint custody ☐ divorced/single custody ☐ other (please explain) _____

Parent Occupation: Mother _____ Father: _____

BIOLOGICAL FAMILY HISTORY Mother's Height _____ Father's Height _____

Condition	Patient	Mother	Father	Sibling	MGF*	MGM*	PGF*	PGM*
Problems with ears/hearing								
Nasal/seasonal allergies								
Asthma								
Lung problems (not asthma)								
Pneumonia (recurrent)								
Heart disease/problem								
History of heart murmur								
High BP								
High cholesterol								
Prolonged QT								
Anemia								
Bleeding or clotting disorder								
Blood transfusion								
HIV								
Organ or bone marrow transplant								
Cancer								
Liver disease								
Constipation (chronic)								
Celiac disease								
Birth defects								
Cystic fibrosis								
Metabolic/genetic disorder								
Kidney disease								
Bedwetting after age 8 years old								
Sleep problems or snoring problems								
Chronic/recurrent skin problems (ie eczema)								
Frequent headaches/migraines								
Convulsions / seizures								
Infections (frequent/requiring hospital)								
Tuberculosis								
Obesity								
Rheumatologic disorder								
Diabetes (adult-onset)								
Diabetes (juvenile-onset)								
Thyroid disorder								
ADHD								
Anxiety								
Mood disorder (depression/bipolar)								
Developmental delay								
Learning problems								
Dental decay or teeth problems								
Sickle cell trait/disease								
Bone/muscle disease								
Alcoholism / drug abuse								
OTHER								

* MGF=Maternal Grand Father MGM=Maternal Grand Mother PGF=Paternal Grand Father PGM=Paternal Grand Mother

Has your child had any of the following?

History of fracture(s)? ☐ Yes ☐ No History of family violence? ☐ Yes ☐ No UTI ☐ Yes ☐ No

History of concussion(s)? ☐ Yes ☐ No Sexually transmitted infections? ☐ Yes ☐ No

History of serious injury? ☐ Yes ☐ No Chicken pox? ☐ Yes ☐ No

IF FEMALE: What was age of first period?_____ Any history of pregnancy? ☐ Yes ☐ No

Your name _____ Signature _____

Relationship to child _____ Today's date _____