Medical History

Completed by _____ (Clinic Use) 2/2020

PATIENT'S BIRTH HISTORY

Name: _____ Date of Birth:_____

Mother's prenatal history:

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 ☐ CESAREAN/Reason: _____
Gestational age at delivery?_____Birth Weight_____
Was Hepatitis B vaccine given? ☐ Yes ☐ No H earing screen passed? ☐ 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

_____
Are there pets at home? ☐ Yes ☐ No If yes please list ___
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
UTI ☐ Yes ☐ No
History of concussion(s)? ☐ Yes ☐ No
Chicken pox? ☐ Yes ☐ No
IF FEMALE: What was age of first period?_____

Your name:_____ Relationship to child:_____ Signature: _____ Today's date:_____