# MEDICAL HISTORY

**PLEASE RETURN THIS FORM TO THE RECEPTIONIST WHEN COMPLETE.**

## PATIENT INFORMATION

| PATIENT'S FULL NAME (CHILD) | DATE OF BIRTH | PREFERRED NAME (NICKNAME) |
|---|---|---|
| MOTHER'S NAME | AGE | OCCUPATION |
| FATHER'S NAME | AGE | OCCUPATION |
| LIST ALL OTHERS LIVING WITH THIS PATIENT (NAME, AGE. RELATION): | | |

**Social History**

Are mother and father (check one): Married ☐ Divorced ☐ Separated ☐

If separated or divorced, who has custody? _____

Does anyone other than a parent have custody? Y ☐ N ☐

If yes, please specify and relationship to the child: _____

Does anyone in the house smoke? Y ☐ N ☐

Does the child attend daycare? Y ☐ N ☐

**Birth History (may skip if completed in the past)**

Was your baby full term (37 weeks or greater)? Y ☐ N ☐

How many weeks?_____

Type of delivery (check one)? C-section ☐ Vaginal ☐

Reason for C-section? _____

Any problems in the hospital or the baby's first few months of life (jaundice, infection, breathing problems, NICU admission)? _____

_____ __

**Past Medical History**

Previous physician of source of care: _____

Does your child see a dentist? Y ☐ N ☐

Has your child ever been hospitalized? Y ☐ N ☐

For what? _____

_____

Has your child ever had surgery? Y ☐ N ☐

What type? _____

_____

What medications does your child take regularly? _____

_____

_____

_____

Any allergies or reactions to medications? _____

_____

Does your child smoke or use tobacco? Y ☐ N ☐

Does your child use alcohol or drugs? Y ☐ N ☐

Has your child had a history of any of the following conditions? (please check)

| | | |
|---|---|---|
| ☐ Asthma/Wheezing | ☐ Allergies | ☐ Anemia |
| ☐ Heart Problems/Murmur | ☐ Kidney Problems | ☐ Pneumonia |
| ☐ Chicken pox | ☐ Sickle Cell Disease or Trait | ☐ HIV/AIDS |
| ☐ Immune System Problems | ☐ Eczema | ☐ Diabetes |
| ☐ Seizure Disorder | ☐ Behavior Problems | ☐ ADD/ADHD |
| ☐ Developmental Delay | ☐ Cerebral Palsy | ☐ Reflux |
| ☐ Migraines | ☐ Neurological Problems | ☐ Food Allergy |
| ☐ Vision Problems | ☐ Hearing Problems | ☐ Depression |
| ☐ Bleeding Problems | ☐ Urinary Tract Infection | ☐ Broken Bones |
| ☐ Rash or skin condition | ☐ Hepatitis | ☐ Tuberculosis |

Has your child received care outside of the practice? Y ☐ N ☐

Does your child see any other physician on a regular basis? If so, please name the physician and provide the last date seen._____

Please list any other medical problems: _____

_____

_____

**Family History**

Please check if a parent, sibling, grandparent, aunt or uncle have any of the following

☐ Anemia ☐ Asthma ☐ Allergies ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems ☐ HIV/AIDS ☐ Hepatitis ☐ Breathing Problems
☐ ADHD/ADD ☐ Depression ☐ Schizophrenia ☐ Alcoholism
☐ Drug Abuse ☐ Tuberculosis ☐ Cancer ☐ Sickle Cell Diseases or Trait
☐ Cystic Fibrosis ☐ Stomach or GI Problems ☐ Mental Illness
☐ Deafness ☐ Vision Problems

Any other medical problems in the family:_____

_____

Lead Screening (Age 5 years and under):

Has your child ever been diagnosed with and elevated lead level?

Y ☐ N ☐ Unsure ☐

Does your child have a sibling or playmate who has or had lead poisoning?

Y ☐ N ☐ Unsure ☐

Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has in the last 6 months been renovated or remodeled?

Y ☐ N ☐ Unsure ☐

Does your child live in or regularly visit a house or child care facility built before 1950?

Y ☐ N ☐ Unsure ☐

**Tuberculosis Screening**

Has your child or a family member or contact ever had a positive TB test?

Y ☐ N ☐ Unsure ☐ Who? _____

Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?

Y ☐ N ☐ Unsure ☐

Has your child traveled to or had contact with people from a county with a high risk of tuberculosis (same as above)?

Y ☐ N ☐ Unsure ☐

**Cholesterol/Heart Disease Screening (Age 2 years and Up)**

Has your child ever been diagnosed with elevated cholesterol?

Y ☐ N ☐ Unsure ☐

Does your child have parents or grandparents with stroke or heart disease before age 55 for men or 65 for women?

Y ☐ N ☐ Unsure ☐

Does your child have a parent with blood cholesterol greater than 240 or take cholesterol medication?

Y ☐ N ☐ Unsure ☐