

## Greenwood Pediatrics Medical History Form

Patient Name \_\_\_\_\_ Date of birth \_\_\_\_\_

**BIRTH HISTORY:**

Baby's Birth Weight \_\_\_\_\_ lb \_\_\_\_\_ oz Baby's Due Date \_\_\_\_\_ weeks  
 Delivery (please check one): Vaginal \_\_\_\_\_ Forceps \_\_\_\_\_ C-Section \_\_\_\_\_ Apgar \_\_\_\_\_ @ 1 \_\_\_\_\_ @ 5  
 Mom's blood Type \_\_\_\_\_ Baby's blood type \_\_\_\_\_ Hospital \_\_\_\_\_  
 Obstetrician \_\_\_\_\_ Mother's age at time of birth \_\_\_\_\_ yrs. Total # of Pregnancies \_\_\_\_\_  
 Number of living children \_\_\_\_\_ Complications of Pregnancy \_\_\_\_\_  
 Medications during Pregnancy: \_\_\_\_\_  
 Complications in Nursery (including jaundice)? Yes / No Explain \_\_\_\_\_  
 \_\_\_\_\_  
 Oxygen needed? \_\_\_\_\_ If so, how long was it used? \_\_\_\_\_

**Family History:** Write in first name of individual below and age. Reading items to right place an X in appropriate boxes that follow. Please provide specific diagnosis in comments section. If DECEASED put cause of death in comments space and age at time of death.

Name	Age	Deceased	Allergies/Asthma	Birth Defects	Bleeding / clotting disorders	Cancer	Mental illness/Substance abuse	Diabetes Mellitus	Eating Disorder/Obesity	Gastrointestinal	High BP or cholesterol	Hearing Loss	Kidney Disease	Heart disease or heart attack before 50	Migraines	Seizures	Thyroid disease	Other / comments
Father																		
Mother																		
Bro. & Sis																		
Maternal grandmother																		
Maternal grandfather																		
Maternal aunts & uncle																		
Paternal grandmother																		
Paternal grandfather																		
Paternal aunts & uncles																		

**Current medications: (include dosages if available):** \_\_\_\_\_

**Social History:**

Marital status \_\_\_\_\_ If divorced/separated please state amount of time child spends with noncustodial parent and list other household members \_\_\_\_\_

Mother's employer/occupation \_\_\_\_\_

Father's employer/occupation \_\_\_\_\_

Year home built \_\_\_\_\_ Pets \_\_\_\_\_ Any second hand smoke exposure? \_\_\_\_\_

**Allergies:** Medications \_\_\_\_\_

Food \_\_\_\_\_

Environmental \_\_\_\_\_

\*\*\*\*\*STOP HERE IF YOUR CHILD IS UNDER 2 MONTHS OF AGE\*\*\*\*\*

**Immunizations:** Up-to-date for age? Yes \_\_\_\_\_ No \_\_\_\_\_ (please provide copy of immunization record)

**Past Medical History:** Circle all that applies. Give dates if possible

- |                |                    |                    |
|----------------|--------------------|--------------------|
| Ear infections | Hives              | Asthma / RAD       |
| Strep throat   | Scarlet fever      | Eczema             |
| Broken bones   | Bladder infections | Seasonal allergies |

Chicken pox \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Please list other Health Care Providers your child sees including the dentist: \_\_\_\_\_

**Development:**

Is your child (circle one): faster....average....or slower....when compared to other children his/her age?

Why? \_\_\_\_\_

Give approximate age your child: smiled \_\_\_\_\_, rolled over \_\_\_\_\_, sat up \_\_\_\_\_, walked \_\_\_\_\_, 1<sup>st</sup> words \_\_\_\_\_, used sentences \_\_\_\_\_, toilet trained – day, \_\_\_\_\_, toilet trained – night \_\_\_\_\_.

Name of school \_\_\_\_\_, present year \_\_\_\_\_, usual grades \_\_\_\_\_.

**Diet History:**

Was your child breast or bottle-fed and for how long? \_\_\_\_\_

Type of formulas used \_\_\_\_\_ Age s/he started solid foods \_\_\_\_\_

How many servings (on average) does your child have each day: dairy \_\_\_\_\_ proteins \_\_\_\_\_ fruits \_\_\_\_\_ vegetables \_\_\_\_\_.

Do you give vitamins / what kind? \_\_\_\_\_ Herbal supplements? \_\_\_\_\_

Any food reactions / intolerances? \_\_\_\_\_

**Review of systems:** Circle any active problems; draw a line through any past problems.

- |                   |                      |                    |                                   |
|-------------------|----------------------|--------------------|-----------------------------------|
| Frequent colds    | Frequent vomiting    | Poor appetite      | Fainting spells                   |
| Ear infections    | Chronic diarrhea     | Excessive thirst   | Headaches                         |
| Sore throats      | Abdominal pain       | Excessive appetite | Numbness/tingling of extremities  |
| Nose bleeds       | Constipation         | Overweight         | Clumsiness / balance problems     |
| Snoring           | Blood in stools      | Underweight        | Dizziness                         |
| Trouble breathing | Soiling of underwear | Recent weight loss | Loss of memory                    |
| Frequent cough    | Bed wetting          | Hearing problems   | Problems paying attention         |
| Wheezing          | Blood in urine       | Vision problems    | Problems getting along with peers |
| Swollen glands    | Painful urination    | Crossed eyes       | Sleep problems                    |
| Easy bruising     | Frequent urination   | Seizures           | Lack of energy                    |
| Trouble in school | Nail biting          | Thumb sucking      | Frequent nightmares               |
| Behavior problems | Learning problems    | Speech problems    | Acne                              |

**Safety: (Yes/No)**

Do you have medications, or other dangerous substances locked away? \_\_\_\_\_ Do you have Poison Control phone number by each phone in the home? \_\_\_\_\_ Do you use car or booster seats for all children under 55 inches? \_\_\_\_\_

Seatbelts? \_\_\_\_\_ Does your child know how to swim? \_\_\_\_\_

Do you have a fire evacuation plan for your home? \_\_\_\_\_ a safe place for everyone to meet? \_\_\_\_\_

Do you have guns in the home? \_\_\_\_\_ If yes how are they stored? \_\_\_\_\_