# 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 name/state_____
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 as they relate to the patient. 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 | High cholesterol | Hearing Loss | Kidney Disease | Heart disease or heart attack before 50 | Migraines | Seizures | Thyroid disease | Other / comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Father | | | | | | | | | | | | | | | | | | | | |
| Mother | | | | | | | | | | | | | | | | | | | | |
| Bro. & Sis | | | | | | | | | | | | | | | | | | | | |
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| Maternal grandmother | | | | | | | | | | | | | | | | | | | | |
| Maternal grandfather | | | | | | | | | | | | | | | | | | | | |
| Maternal aunts & uncles | | | | | | | | | | | | | | | | | | | | |
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| Paternal grandmother | | | | | | | | | | | | | | | | | | | | |
| Paternal grandfather | | | | | | | | | | | | | | | | | | | | |
| Paternal aunts & uncles | | | | | | | | | | | | | | | | | | | | |
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**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_____
Enviromental_____

****************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_____,
1st 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? _____