MEDICAL HISTORY FORM

Name: ______________________________ Chart # ______________

Date of Birth: ______________________________ Sex: [ ] Male [ ] Female

BIRTH HISTORY

When was your baby born: on time, more than one month early, or late? ______________

Were there any complications with the pregnancy or delivery? ______________

Were there any complications after birth? ______________

Type of delivery: [ ] Vaginal Delivery [ ] C-Section Place of Birth ______________

At birth, what was your baby's: Weight ______________ Length ______________ APGARS ______________

Was your baby: [ ] bottle fed [ ] breast fed [ ] both

FAMILY HISTORY

Has any one in your child's family had:

Illness		Relationship	Illness		Relationship
High Blood Pressure	[ ] yes [ ] no		Seizures	[ ] yes [ ] no	
Heart Attack at age <60	[ ] yes [ ] no		Sickle Cell Anemia	[ ] yes [ ] no	
Diabetes	[ ] yes [ ] no		Asthma	[ ] yes [ ] no	
Stroke at age < 60	[ ] yes [ ] no		Tuberculosis	[ ] yes [ ] no	
Cancer	[ ] yes [ ] no		Mental Illness	[ ] yes [ ] no	
Thyroid Problems	[ ] yes [ ] no		Migraine Headaches	[ ] yes [ ] no	
Allergic Disorders (Hay fever, Eczema)	[ ] yes [ ] no		Other	[ ] yes [ ] no	

Medical, Surgical History

Is your child allergic to any medications? ______________

Is you child currently taking any medications? ______________

Does your child have any current medical problems? ______________

Has your child had any surgery or hospitalizations? If yes, please list approximate dates and/or procedure:

Social History

Do you have: [ ] city water [ ] well water?

Are there any smokers in the home? [ ] yes [ ] no

Is your child in daycare (if under age 5)? [ ] yes [ ] no

Names and ages of persons living in home with patient: ______________

Name of person completing form ______________

Relation to child ______________ Date: ______________

Updated: ________ ________ ________ Reviewed By: ________