Patient Medical History

Patient Name: ___________________________________ Birthdate: _______________________

Allergies: (check all that apply; detail type of reaction (e.g. "Penicillin – hives")

☐ No Known Allergies
☐ Medications: ____
☐ Food: ____
☐ Insects bites: ____
☐ Immunizations: ____
☐ Other: ____

Current Medications: (include routine medications and medications used on as needed basis)

____
____

Specific Concerns you have about your child you would like to be addressed:

____
____

Birth History:

Patient is your child by: ☐ Birth ☐ Adoption ☐ Foster Care ☐ Surrogate birth ☐ Marriage
Patient was born at: ☐ Hospital (name) _____________________ ☐ Home
Type of Birth: ☐ Vaginal ☐ Caesarean Reason for Caesarean: _____________________
Baby was born: ☐ Full-Term ☐ Premature, at ____________________weeks gestation
Birth weight: ____________________________ Birth Height: _________________________
Complications at birth: ____ ☐ None
Maternal Complications before or after birth: _______________________________________ ☐ None

Developmental History:

What age did the patient:

Sit up unassisted ______________________ Crawl _______________________________
Walk alone __________________________ Say first word __________________________
Toilet train ___________________________

☐ Don't Recall, but has had normal development

Patient's Past Medical History:

☐ No significant medical conditions
Chronic Medical Conditions: ____
____
Hospitalizations (incl. dates and reasons): ____
____
Surgeries (incl. dates and reasons): ____
Fractures/Serious Sprains (incl. dates and reasons):____________________________________

Family History: Please check all that apply and indicate who is affected by the condition

- ☐ Allergies
- ☐ Allergies
- ☐ Asthma
- ☐ Anemia
- ☐ Birth Defect
- ☐ Blindness (including color blindness)
- ☐ Bleeding disorders/clotting disorders
- ☐ Cancer (please specify type: ___________________)
- ☐ Childhood Hearing Loss
- ☐ Cholesterol Problems
- ☐ Developmental Delays (incl. autism)
- ☐ Drug Abuse (including alcohol)
- ☐ Eczema
- ☐ Heart Disease or stroke before age 60
- ☐ High blood pressure
- ☐ Inherited/Genetic Diseases
- ☐ Kidney Disease
- ☐ Premature Death (SIDS, etc.)
- ☐ Psychiatric Disorders
- ☐ Seizures
- ☐ Thyroid Disorder
- ☐ Other:

Social History:

Patient lives at home with:

Name:	Age:	Relationship:
________________________	__________	____________________________
________________________	__________	____________________________
________________________	__________	____________________________
________________________	__________	____________________________
________________________	__________	____________________________
________________________	__________	____________________________

Patient's parents are: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced (when? _____________)

____ ____

Parent Name Parent Occupation

____ ____

Parent Name Parent Occupation

Pets at home: ☐ None ☐ Birds ☐ Cats ☐ Dogs ☐ Other: _______________

Are there smokers in the home? ☐ Yes ☐ No Is violence at home a concern? ☐ Yes ☐ No

Are there firearms in the home? ☐ Yes ☐ No If yes, are the firearms secured? ☐ Yes ☐ No

How did you hear about our office?

☐ Friend ☐ OB/Gyn MD ☐ Internet ☐ Huntington Memorial Hospital ☐ Other: ___________________

Whom may we thank for referring you to our office? ____