Medical History

Patient Name: ____ DOB:________________

Pregnancy & Birth (answer or circle what applies)

Mother's Age at child's birth? ____________
Maternal **Illness** during pregnancy or early labor? ____
Any **Medications**, **Smoking** or **Alcohol** used during pregnancy? ____
Was your baby born **Premature**? Yes-[] No-[] How many **Weeks of Gestation**?_______________________
What was the **Birth Weight**?_____________ **Birth Length**? ____________
Passed **Hearing Test**? Yes-[] No-[] Received **HEP B-#1** Shot? Yes-[] No-[]
What type of **Delivery**?----- []Vaginal [] Caesarian []Vertex []Breech
Were any of the **Maternal labs** positive? Yes-[] No-[] If Yes, Which Ones?_____________________________________
(Rubella, Hepatitis B, Syphilis, HIV, Herpes, Group B Strep)
Did the baby have **Complications** while in the hospital? If "yes", list: ______________________________________
(infection, jaundice, breathing difficulties, NICU……..)____

Past Medical History (refers to child)

Any **Allergies** (Medications, Foods, Other)? Yes[] No[]-If yes which ones? _______________________________
Any overnight **Hospitalizations**? Yes[] No[]-If yes why and at what age? __________________________
Any **Surgeries**? Yes[] No[]-If yes, what kind, at what age? ________________________
Any **Medications** taken regularly? Yes[] No[]-If yes, which medications? ________________________
Are **Immunizations** up to date? Yes[] No[]

Check any **Medical Problems** your child has or had: ☐ Urinary Tract Infections ☐ Asthma ☐ Frequent Strep Throat

☐ Frequent Ear Infections ☐ Pneumonia ☐ Anemia ☐ Heart Problems
☐ Vision/Hearing Problems ☐ Allergies ☐ Seizures ☐ School Problems
☐ Emotional/Behavior Problems ☐ Speech Problems ☐ Constipation ☐ Lyme Disease
☐ Developmental Delay

List any **Other Medical Problems** your child has had that are not listed above _______________________________
Preferred Pharmacy: Name/Location_______________________________________ Phone: _____________
If there is no preferred pharmacy for the patient the Walgreens located at 915 Gessner Suite 200 will be used
Does your child see a **Specialist**? Yes[] No[]-If yes who, and what specialty________________________________

Family History

Check any diseases that the child's parents, siblings, grandparents had and indicate who had it.

☐ Cholesterol ☐Cancer ☐ Epilepsy ☐ Alcoholism
☐ High Blood Pressure ☐ Diabetes ☐ Migraine ☐ AIDS
☐ Asthma ☐ Allergies ☐ Mental Retardation ☐ Drug Addiction
☐ Tuberculosis ☐ Heart Diseases ☐ Sudden Death before age 50 yrs.

List any other significant chronic illnesses in the family ____
Any cigarette **Smoking** in the house? ______________________________________
Was the house built **Before 1978**? _______________________________________
Who does the **Child Live** with? []Both parents []Mom []Dad []Foster Care []Adopted []Other________________
Form Completed by:_______________________________ Signature:___________________________

Relation to Patient:_________________________ Date:______________________