PATIENT MEDICAL HISTORY FORM TRI-COUNTY PEDIATRIC ASSOCIATES, P.C.

Name_____
first last

Date of Birth_____/_____/_____
month / day / year

Mother's Name_____
first last

Today's Date _____

Previous Pediatrician _____
address _____
_____
Previous Pediatrician phone # _____

PREGNANCY AND BIRTH HISTORY

Mother's age at child's birth _____
Illness or problems during pregnancy_____
Medications during pregnancy _____
Smoking/alcohol/street drugs during pregnancy _____
Was baby born on time/early/late? _____ # of weeks _____
Type of delivery _____ Birth weight _____
Complications/problems with labor/delivery_____
_____
Problems with baby at or after birth _____
_____
Feeding (please circle) breast bottle combination of both

CHILD'S PAST MEDICAL HISTORY

Significant illnesses/ongoing health issues _____
_____
Hospitalizations _____
Serious Injuries _____
Immunizations up to date? yes no
Any reactions to vaccines? _____
Do you have a record of immunizations? yes no
Allergies (medications/foods/animals/insects) _____
_____
Medications taken on regular basis?
(incl. Vitamins/herbals/supplements)_____
_____

SOCIAL HISTORY

Are parents: Married ___ Separated ____ Divorced ____ Deceased ___
Mother's occupation _____
Father's occupation _____
Who else lives at home? _____
Main daytime care _____
Pets in home? _____
Age of home? (if known) _____
Smokers in home? yes no Weapons in home? yes no
Language other than English spoken at home _____
Lead poisoning in other children yes no

FAMILY MEDICAL HISTORY

Mother's age _____
Mother's health issues_____
Father's age _____
Father's health issues _____
Siblings:
name_____ age _____
health issues _____
name _____ age _____
health issues _____
name _____ age _____
health issues _____
name _____ age _____
health issues _____

List all relatives of child who have/had any of the following: (Parents/Grandparents/Aunts/Uncles/Cousins)

Anemia/Blood disorder _____
Asthma _____
Allergies _____
Mental Retardation/Developmental Issues _____
_____
Diabetes_____
High Blood Pressure _____
High Cholesterol level _____
Cancer _____
Epilepsy/Seizures _____
Drug/Alcohol Problem _____
Mental Illness _____
Arthritis _____
Kidney/Urinary Disorder _____
Thyroid Disease _____
Cystic Fibrosis _____
Muscular Dystrophy _____
Obesity _____
Learning Disorder _____
Migraine _____
Birth Defects _____
Early Deafness _____
Sudden Infant Death (SIDS) _____
Have any of your children died? _____