medical history

Children's Medical Group, S.C.

PATIENT AND FAMILY MEDICAL HISTORY

Your child's overall health history as well as the health and social history of your family can have an important impact on the care your child receives. Please be as thorough and specific about medications, illnesses and diseases inquired about on this form.

Child's Name: _____ DOB: _____ Sex: M F T

PATIENT MEDICAL HISTORY

BIRTH HISTORY:

Gestational Age (number of weeks in pregnancy) _____ /40 weeks

Birth Weight _____ lbs _____ oz

Discharge Weight _____ lbs _____ oz Discharge Date: _____

How was your child born? vaginally c-section

Did your child pass the newborn hearing screen? Yes No

Did your child receive the Hepatitis B vaccine? Yes No

What type of feedings do you do? Breastmilk Formula Both

What hospital was your child born at? _____

MEDICAL HISTORY:

Does your child have, or has he/she ever had, any of the following conditions? If so, please indicate the date or year.

Congenital heart defect	No	Yes	_____	Chicken pox	No	Yes	_____
Heart murmur	No	Yes	_____	Mono	No	Yes	_____
Hypertension	No	Yes	_____	Kidney disease	No	Yes	_____
Pneumonia/Lung disease	No	Yes	_____	Urinary tract infections	No	Yes	_____
Asthma	No	Yes	_____	Vesicoureteral Reflux	No	Yes	_____
Wheezing	No	Yes	_____	Diabetes	No	Yes	_____
Allergies/Hay fever	No	Yes	_____	Cerebral palsy	No	Yes	_____
Eczema	No	Yes	_____	Seizure disorder	No	Yes	_____
Elevated lead level	No	Yes	_____	Migraines	No	Yes	_____
Leukemia/Lymphoma	No	Yes	_____	Learning disability	No	Yes	_____
Other cancers	No	Yes	_____	Emotional disorder	No	Yes	_____
Hepatitis	No	Yes	_____	STD	No	Yes	_____
Bleeding disorder	No	Yes	_____	HIV/AIDS	No	Yes	_____
Thyroid Dysfunction	No	Yes	_____	ADD/ADHD	No	Yes	_____
Rheumatic fever	No	Yes	_____	Drug or alcohol abuse	No	Yes	_____

ALLERGIES: _____

_____

_____

MEDICATIONS: _____

_____

_____

(continued on opposite side)

PATIENT MEDICAL HISTORY (continued)

SURGICAL HISTORY:

Please indicate any surgical procedures your child may have had, including the date the procedure took place (other than circumcision at birth).

_____ Date: _____

_____ Date: _____

HOSPITALIZATIONS:

Please indicate the reason and date your child may have been hospitalized in the past (other than birth).

_____ Date: _____

_____ Date: _____

FAMILY MEDICAL HISTORY

Do any family members have any of the following conditions? **If so, who**? **(and please indicate maternal or paternal relation)**

Asthma	No	Yes_____	Thyroid Disorders	No	Yes_____
Heart Disease	No	Yes_____	Bleeding Disorders	No	Yes_____
High Cholesterol	No	Yes_____	Sickle Cell Anemia or Trait	No	Yes_____
Diabetes	No	Yes_____	Rheumatoid Arthritis	No	Yes_____
Lupus	No	Yes_____	Inflammatory Bowel Disease	No	Yes_____
Leukemia	No	Yes_____	Alcohol Use/Abuse	No	Yes_____
Lymphoma	No	Yes_____	Drug Use/Abuse	No	Yes_____
Other Cancers (what type?)	No	Yes_____	Tuberculosis	No	Yes_____
Cystic Fibrosis	No	Yes_____	HIV/AIDS	No	Yes_____
Kidney Disorders	No	Yes_____	Mental/Emotional Problems	No	Yes_____

SOCIAL HISTORY

Who lives with the patient? _____

Are the child's biological parents: Single Married Divorced Remarried

What language is spoken in the home? Primary language: _____ Other languages: _____

What category best describes the child's race? ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Multiracial

(please check all that apply) ☐ Black or African American ☐ Asian (includes Pakistan or Indian origin) ☐ White

☐ Hispanic ☐ Other _____ ☐ Decline

Would your child identify with being Hispanic or Latino? Yes No Decline

Does (or will) your child attend daycare? Yes No

Do any of them smoke? Yes No If so, who? _____ inside home outside home

Do you have pets? Yes No If so, what kind? _____

Are there any guns in the house? Yes No If so, are they loaded? Yes No Are they locked? Yes No

Do you use a car seat or booster seat? Yes No

What type of water service do you have in your home? City Well

What year was your current residence built? _____

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform my child's physician of any changes in my child's medical status.

X _____ Date: _____

Signature of Parent or Legal Guardian