Celebration Pediatrics

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PEDIATRIC PATIENT MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____

Birth History

Birth Weight_____ Preg#____Mom's age_____Was the birth □ Vaginal? □ Cesarean? □ Early? □ Late?

If birth was early, how many weeks early?_____If Cesarean, why? _____

Did mother have any illnesses/problems with her pregnancy? □ Yes □ No Explain _____

Did baby have any problems right after birth? □ Yes □ No Explain_____

Before mother knew she was pregnant or at any time during her pregnancy did she:

□ Smoke Cigarettes (amount) _____ □ Drink Alcohol (amount) _____

□ Use "street" drugs (type) _____ □ Use Prescription Drugs (type) _____

Was initial feeding □ Breast Milk? □ Formula

Current and Past History

Is your child currently on any medication?	□ Y	□ N	Explain: _____
Does your child have any serious or chronic illnesses?	□ Y	□ N	Explain: _____
Has your child had serious injuries or accidents?	□ Y	□ N	Explain: _____
Has your child had any surgeries?	□ Y	□ N	Explain: _____
Has your child ever been hospitalized?	□ Y	□ N	Explain: _____
Is your child allergic to any medications?	□ Y	□ N	Explain: _____

Does Your Child Have or Has Your Child Ever Had:

Asthma, recurrent cough, bronchitis, or pneumonia	□ Y	□ N	Explain: _____
Nasal allergies or eczema	□ Y	□ N	Explain: _____
Frequent ear infections or sore throat	□ Y	□ N	Explain: _____
Problems with ears or hearing	□ Y	□ N	Explain: _____
Problems with eyes, vision or teeth	□ Y	□ N	Explain: _____
Frequent headaches or other neurologic problems	□ Y	□ N	Explain: _____
Frequent abdominal pain	□ Y	□ N	Explain: _____
Constipation requiring doctor visits	□ Y	□ N	Explain: _____
Bladder/kidney problems or bedwetting	□ Y	□ N	Explain: _____
Any heart problems/murmur	□ Y	□ N	Explain: _____
Anemia or bleeding problem	□ Y	□ N	Explain: _____
Thyroid or other gland problem	□ Y	□ N	Explain: _____
Diabetes	□ Y	□ N	Explain: _____
ADD/ADHD	□ Y	□ N	Explain: _____
Mental Health Issues	□ Y	□ N	Explain: _____
Use of drugs or alcohol	□ Y	□ N	Explain: _____

Household Information

Please list all those living in the child's household

Name	Relationship to child	DOB

Are there siblings not listed above? If so, please list their full names and ages and where they live

Sibling Name	Location	Age

Child Care: _____

Smokers in household? □ Y □ N

Family Medical History (Parents, Siblings, Grandparents, Aunts, and Uncles)

Have Any Family Members Had the Following:

Alcohol/Drug Abuse	□ Y	□ N	Who: _____	Comments _____
Allergies	□ Y	□ N	Who: _____	Comments _____
Asthma	□ Y	□ N	Who: _____	Comments _____
Birth Defects	□ Y	□ N	Who: _____	Comments _____
Blood disorders	□ Y	□ N	Who: _____	Comments _____
Bone disorders	□ Y	□ N	Who: _____	Comments _____
Cancer	□ Y	□ N	Who: _____	Comments _____
Diabetes	□ Y	□ N	Who: _____	Comments _____
Endocrine Disease	□ Y	□ N	Who: _____	Comments _____
Ear / Nose / Throat	□ Y	□ N	Who: _____	Comments _____
Disorders	□ Y	□ N	Who: _____	Comments _____
Heart Disease	□ Y	□ N	Who: _____	Comments _____
High Blood Pressure	□ Y	□ N	Who: _____	Comments _____
High Cholesterol	□ Y	□ N	Who: _____	Comments _____
Immune Disorder	□ Y	□ N	Who: _____	Comments _____
Joint Problems	□ Y	□ N	Who: _____	Comments _____
Kidney Disease	□ Y	□ N	Who: _____	Comments _____
Liver Disease	□ Y	□ N	Who: _____	Comments _____
Lung Disease	□ Y	□ N	Who: _____	Comments _____
Migraine Headaches	□ Y	□ N	Who: _____	Comments _____
Metabolic Disorders	□ Y	□ N	Who: _____	Comments _____
Obesity	□ Y	□ N	Who: _____	Comments _____
Seizure Disorders	□ Y	□ N	Who: _____	Comments _____
Skin Disorders	□ Y	□ N	Who: _____	Comments _____
Stroke History	□ Y	□ N	Who: _____	Comments _____
Thyroid Disorders	□ Y	□ N	Who: _____	Comments _____
Mental Health History	□ Y	□ N	Who: _____	Comments _____
Other Medical History	□ Y	□ N	Who: _____	Comments _____
Other Medical History	□ Y	□ N	Who: _____	Comments _____

_____ _____ _____

Signature of Person Completing This Form Date Relationship to Patient