MOUNT MEEKER PEDIATRICS

Medical History

Child First Name: _____ Last Name: _____ DOB: _____

Is your child adopted? □ Yes □ No Is your child a foster child? □ Yes □ No

Birth weight: _____ Weeks' gestation: _____ Delivery: □ C-Section □ Vaginal

If C-Section, why? _____

Did mom have any illnesses/problems during pregnancy? □ Yes □ No If yes, please explain:

_____

Any complications at birth or a NICU stay? □ Yes □ No If yes, please explain:

_____

Does your child have any allergies to medications, pets, plants, food, etc.? □ Yes □ No

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Describe Reaction

Please list ALL current medications, including over-the-counter supplements and herbs:

Medication	Dose and Frequency	Medication	Dose and Frequency

Please list any surgeries or hospitalizations and the date (month/year):

Procedure or Hospital Stay	Date(s)

Has your child had (or does your child currently have):

Any chronic medical problems such as asthma, allergies, eczema, ear infections, diabetes, etc.?

_____

_____

Any past or current developmental delays (speech, motor), ADHD, or autism spectrum disorder?

_____

_____

Any behavioral challenges? _____

_____

_____

Family Medical history: Please check "yes" if any of your child's **parents, grandparents, siblings, aunts, or uncles** have any medical issues. If "yes," tell us which family member has that issue (please specify mom or dad's side) and any details about that medical issue.

Medical Condition:		**Who has it, and any details:**
Allergies	□ Yes □ No	_____
Asthma	□ Yes □ No	_____
Bleeding/clotting disorder	□ Yes □ No	_____
Cancer	□ Yes □ No	_____
Diabetes	□ Yes □ No	_____
Celiac disease	□ Yes □ No	_____
Crohn's or ulcerative colitis	□ Yes □ No	_____
Heart disease	□ Yes □ No	_____
High blood pressure	□ Yes □ No	_____
High cholesterol	□ Yes □ No	_____
Joint problems	□ Yes □ No	_____
Kidney disease	□ Yes □ No	_____
Liver disease	□ Yes □ No	_____
Mental health problems	□ Yes □ No	_____
Migraine headaches	□ Yes □ No	_____
Obesity	□ Yes □ No	_____
Seizure disorders	□ Yes □ No	_____
Substance abuse	□ Yes □ No	_____
Thyroid disorders	□ Yes □ No	_____
Other (please specify)	□ Yes □ No	_____

Please list everyone who lives with your child:

_____

_____

_____

Do any pets live with your child? If yes, list them: _____
Does anyone at home smoke or vape? □ Yes □ No
Does your child attend a day care? □ Yes □ No
In the car, does your child ride in a: □ carseat □ booster seat □ neither
If guns are in the home, how are they stored? _____ □ None at home
Can your child swim independently? □ Yes □ No

Please share any other needs or preferences below that will help us serve you better! Any fears or sensitivities surrounding doctor visits, or other preferences we should respect?

_____

_____