

ADVANCED PEDIATRIC ASSOCIATES

Patient Medical History Form

Date	Child's Name	Nickname	DOB	M	F
Previous Physician/Office		Request for Records Transfer Complete Y N		Date of Last Physical	
Mother's Name			Occupation		
Age			Father's Name		
Occupation			Age		
Birth History					
Birth weight _____		Preg # _____		Mom's age _____	
Was the baby born on time? _____		Early? _____		Late? _____	
If early, how many weeks gestation? _____					
Did mother have any illness or problems with her pregnancy? <input type="checkbox"/> Y <input type="checkbox"/> N					
Explain _____					
During pregnancy, did mother:					
Smoke <input type="checkbox"/> Y <input type="checkbox"/> N					
Use drugs or medications <input type="checkbox"/> Y <input type="checkbox"/> N					
What _____ When _____					
Was the delivery <input type="checkbox"/> Vaginal?		<input type="checkbox"/> Cesarean?			
If Cesarean, why? _____					
Did your baby have any problems right after birth? <input type="checkbox"/> Y <input type="checkbox"/> N					
Explain _____					
Was initial feeding <input type="checkbox"/> Breast Milk? <input type="checkbox"/> Formula?					
Did your baby go home with mother from the hospital? <input type="checkbox"/> Y <input type="checkbox"/> N					
Explain _____					
Current and Past History					
Is your child currently on any medication?		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Does your child have any serious or chronic illnesses?		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Has your child had serious injuries or accidents?		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Has your child had any surgery?		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Has your child ever been hospitalized?		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Is your child allergic to any medicine or drugs?		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Has your child had any reactions to immunizations?		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Does Your Child Have, or Ever Had:					
Asthma, recurrent cough, bronchitis, or pneumonia		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Nasal allergies or eczema		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Frequent ear infections or sore throats		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Problems with ears or hearing		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Problems with eyes, vision, or teeth		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Frequent headaches or other neurologic problems		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Frequent abdominal pain		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Constipation requiring doctor visits		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Bladder/kidney infection or bed-wetting (after 5 years old)		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Any heart problem or heart murmur		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Anemia or bleeding problem		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Thyroid or other endocrine problem		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Diabetes		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
ADHD		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Mental health issues (anxiety, depression)		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Use of alcohol or drugs		<input type="checkbox"/> Y <input type="checkbox"/> N Explain _____			
Any other medical or mental health issues/problems _____					
Does your child see any specialists? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, Who? _____					
For what reason or diagnosis? _____					
Has your child ever received Occupational Therapy, <input type="checkbox"/> Y <input type="checkbox"/> N Explain _____					
Physical Therapy, Speech Therapy?					
Is your child in special or resource classes in school? <input type="checkbox"/> Y <input type="checkbox"/> N Explain _____					
Do you have any other issues or concerns not listed above? _____					

Household Information

Please List All Those Living in the Child's Home

Name	Relationship to Child	DOB

Child Care: _____

Smokers in household? Y N Pets in household? Y N

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

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

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

Have Any Family Members Had The following:

- Alcohol/Drug Abuse Y N Who _____ Comments _____
- Allergies Y N Who _____ Comments _____
- Anesthesia Risk Y N Who _____ Comments _____
- Arthritis Y N Who _____ Comments _____
- Blood Disease Y N Who _____ Comments _____
- Cancer Y N Who _____ Comments _____
- Diabetes Y N Who _____ Comments _____
- Genetic Y N Who _____ Comments _____
- Gastroenteritis Y N Who _____ Comments _____
- Genitourinary Y N Who _____ Comments _____
- Heart Y N Who _____ Comments _____
- Hypertension Y N Who _____ Comments _____
- Lipids Y N Who _____ Comments _____
- Neurologic Diagnosis Y N Who _____ Comments _____
- Psychiatry Y N Who _____ Comments _____
- Ophthalmology Y N Who _____ Comments _____
- Respiratory Y N Who _____ Comments _____
- Skin Y N Who _____ Comments _____
- Stroke Y N Who _____ Comments _____
- Thyroid Y N Who _____ Comments _____
- Negative Family History Y N Who _____ Comments _____

Additional Family History/Comments _____

Initial Review (initials/date):