Patient Medical History Form

Date _____

Patient Name_____Birth Date _____

Your Name_____Relationship to Patient _____

Medication Allergies_____Chronic Medications _____

We are updating our system. If you are a new or established patient, please complete the following information for your child. Please complete a separate form for each patient. Additional forms may be printed from our website www.northsidepediatrics.com.

Pregnancy History

Did mom see a perinatologist during pregnancy? ❒Yes ❒No	Did mom smoke during pregnancy? ❒Yes ❒No
Did mom have an abnormal ultrasound during pregnancy? ❒Yes ❒No	Did mom drink any alcoholic beverages during pregnancy? ❒Yes ❒No
Has mom had breast surgery? ❒Yes ❒No	Has mom had any miscarriages, still births, or abortions? ❒Yes ❒No

Were there any complications during pregnancy? If so, please list: _____

_____

Birth History

❒Full term pregnancy ❒Premature birth at____weeks ❒Twin or multiple births at____weeks

Baby's weight at birth? _____

Were there any problems during labor? If so, please list: _____

_____

Type of Delivery: ❒Vaginal ❒C-Section Apgars_____ Was the baby ever breech (feet first)? ❒Yes ❒No

Did the baby have any problems during the newborn period? If so, please list: _____

_____

Was the child the product of IVF? ❒Yes ❒No Was the child the product of artificial insemination? ❒Yes ❒No

Was the child the product of a donor egg? ❒Yes ❒No Was the child adopted? ❒Yes ❒No

Developmental

Sat alone at_____mos. Walked at_____mos. Words at_____mos. Sentences at_____mos.

Were there any concerns for your child's development in the past? ❒Yes ❒No

Does the child have any disability? ❒Yes ❒No If yes, please specify: _____

Has your child ever needed to see a physical, speech or occupational therapist? If so, please list: _____

_____

11/2020

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Past Medical History Form

Date: _____

Patient Name:_____ **DOB:**_____

Has your child ever been diagnosed with any of the following health issues? Please indicate each one.

Allergies
Environmental ❒Yes ❒No
Food ❒Yes ❒No
Allergy Testing ❒Yes ❒No
Allergy Shots ❒Yes ❒No
Eczema ❒Yes ❒No
History of Anaphylaxis? ❒Yes ❒No
Other (Please List)_____

Cardiac
Heart Defect ❒Yes ❒No
Other (Please List)_____

Developmental/Genetic Disorders
Down Syndrome ❒Yes ❒No
Turner Syndrome ❒Yes ❒No
Mitochondrial Disease ❒Yes ❒No
Autistic Spectrum Disorder ❒Yes ❒No
Other (Please List)_____

Ear/Nose and Throat
Ear Infections (more than 5 in a year) ❒Yes ❒No
Tonsillitis (recurrent) ❒Yes ❒No
Sleep Apnea ❒Yes ❒No
Other (Please List)_____

Endocrine
Hypothyroid ❒Yes ❒No
Hyperthyroid ❒Yes ❒No
Type I Diabetes ❒Yes ❒No
Type II Diabetes ❒Yes ❒No
Other (Please List)_____

Eye
Strabismus (crossed eyes) ❒Yes ❒No
Amblyopia (decreased vision) ❒Yes ❒No
Other (Please List)_____

Gastrointestinal
Reflux ❒Yes ❒No
Constipation ❒Yes ❒No
Chronic Abdominal Pain ❒Yes ❒No
Celiac Disease ❒Yes ❒No
Other (Please List)_____

Genitourinary
Urinary Infections ❒Yes ❒No
Menstrual Problems ❒Yes ❒No
Vesicoureteral Reflux (kidney reflux) ❒Yes ❒No
Bedwetting (over the age of 6) ❒Yes ❒No
Other (Please List)_____

Hematology
Anemia ❒Yes ❒No
Other (Please List)_____

Infections/Immunology
Chicken Pox ❒Yes ❒No
MRSA ❒Yes ❒No
Immunodeficiency ❒Yes ❒No
Other (Please List)_____

Lung
Pneumonia ❒Yes ❒No
Asthma or wheezing ❒Yes ❒No
RSV (respiratory syncytial virus) ❒Yes ❒No
Other (Please List)_____

Mental Health
Depression ❒Yes ❒No
Anxiety ❒Yes ❒No
Other (Please List)_____

Neurologic
Recurrent Headaches ❒Yes ❒No
Cerebral Palsy ❒Yes ❒No
Seizure Disorder ❒Yes ❒No
ADHD
Predominantly Inattentive ❒Yes ❒No
Predominantly Hyperactive ❒Yes ❒No
Combined ❒Yes ❒No
Other (Please List)_____

Obesity ❒Yes ❒No

Oncology/Cancer ❒Yes ❒No
Other (Please List)_____

Orthopedic
Fractures and When ❒Yes ❒No
What bone?_____
What bone?_____
What bone?_____
Scoliosis ❒Yes ❒No
Other (Please List)_____

Please list any details if you answered **"Yes"** to any of the above:

List any hospitalizations that your child has had:

Other illnesses:

Past surgery:

Sees Specialist Doctor: ❒Yes ❒No If yes, what kind?

For what?

Name of Specialist Doctor(s):

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11/5/18

Family History Form

Date: _____

Patient Name:_____ **DOB:**_____

Has anyone in your family been diagnosed with the following health issues? Please be sure to only consider the **CHILD'S parents, siblings, grandparents, aunts, uncles, first cousins, etc. Please also indicate/write next to each diagnosis which first degree family member has or had each health issue (i.e. maternal aunt, paternal grandfather, etc.).**

Allergies
Asthma ❒Yes ❒No
Environmental ❒Yes ❒No
Food ❒Yes ❒No

Birth Defects ❒Yes ❒No

Bleeding Disorders ❒Yes ❒No

Cancer ❒Yes ❒No

Cardiovascular
Heart Attack before 50 ❒Yes ❒No
Stroke before 50 ❒Yes ❒No
High Blood Pressure ❒Yes ❒No
High Cholesterol ❒Yes ❒No
High Triglycerides ❒Yes ❒No
Other ❒Yes ❒No

Development
Learning Disorder ❒Yes ❒No
Developmental Disorder ❒Yes ❒No
Autism ❒Yes ❒No
ADD/ADHD ❒Yes ❒No
Other ❒Yes ❒No

Diabetes
Type I (Juvenile) ❒Yes ❒No
Type II (Adult) ❒Yes ❒No

Gastrointestinal
Celiac Disease ❒Yes ❒No
Inflammatory Bowel Disease ❒Yes ❒No
Irritable Bowel Syndrome ❒Yes ❒No
Peptic Ulcer Disease ❒Yes ❒No
Other ❒Yes ❒No

Genetic Disorders ❒Yes ❒No

Hearing Loss/Deafness ❒Yes ❒No

Kidney Disease
Kidney Reflux ❒Yes ❒No
Recurrent Infections ❒Yes ❒No
Congenital Malformations (abnormally formed kidneys) ❒Yes ❒No
Kidney Failure/Transplant ❒Yes ❒No
Other ❒Yes ❒No

Lazy Eye ❒Yes ❒No

Mental or Emotional Disorders
Anxiety ❒Yes ❒No
Bioplar Disorder ❒Yes ❒No
Depression ❒Yes ❒No
Schizophrenia ❒Yes ❒No
Substance Abuse (drugs or alcohol) ❒Yes ❒No
OCD ❒Yes ❒No
Other ❒Yes ❒No

Migraines ❒Yes ❒No

Obesity ❒Yes ❒No

Seizure Disorder ❒Yes ❒No

Thyroid Disease
Hypothyroid ❒Yes ❒No
Hyperthyroid ❒Yes ❒No
Thyroid Tumor ❒Yes ❒No

Please list any other problems in the family:

_____

_____

_____

2/26/20

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Social History Form

Date _____

Patient Name _____ DOB _____

Please complete the following information for your child.

Recent Changes: ❒Move ❒Loss of Job ❒Other, please list: _____
❒Travel ❒Death Date of change: _____

Parents Marital Status: ❒Married ❒Divorced Date: _____ ❒Separated Date: _____
❒Single ❒Widowed Date: _____ ❒Unmarried Living Together
❒Remarried Parent 1 Name _____ Date _____
Parent 2 Name _____ Date _____

Parents Occupation: Parent 1 _____/_____ Parent 2 _____/_____
Name Occupation Name Occupation

Members of Household: Parent 1 _____ Parent 2 _____
Name Name
Brother #_____ Sister #_____ Other, please list: _____

Other Living Arrangements: ❒Legal Guardian ❒Adopted ❒Foster Care
❒Parent(s) Incarcerated ❒Parent(s) in Drug/Alcohol Rehab
❒Child Protective Services Involved Who is primary caregiver? _____

Is there tobacco or smoke exposure? ❒Yes ❒No

Are there guns in the home? ❒Yes ❒No ❒Decline to answer If yes, are they? ❒Secured ❒Unsecured

School Arrangements: ❒Daycare ❒Preschool ❒In School ❒Home School
What grade? _____ Name of school_____
Academic performance ❒Excellent ❒Good ❒Average ❒Poor

Any clubs or athletic teams? ❒Yes ❒No If yes, please list: _____

_____

Any pets in the home? ❒Dog ❒Cat ❒Other, please list: _____

TB exposure risks: ❒Contact w/TB ❒Contact w/HIV ❒Contact w/Immigrant ❒Contact w/Prisoner
❒Contact w/Homeless ❒Immunosuppression ❒Foreign Travel (for 1 month+)
❒High Risk Community ❒Other, please list: _____ ❒None

Lead exposure risks (if your child is under 6 years of age): ❒Older Home (before 1978) ❒Recent Remodeling
❒Paint Removal ❒Occupational Exposure ❒Pica (child eats dirt, rocks, paper, plastic, etc.)
❒Other, please list: _____ ❒None

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