ALL ABOUT FAMILY MEDICINE

Pediatric/Adolescent Medical History
(NEW PATIENTS ONLY)

Date of Visit: ___/___/_____

Child's Full Name	DOB	Nickname	Home Phone
Father	Age	Occupation	Work Phone
Mother	Age	Occupation	Work Phone
Stepparent/Guardian	Age	Occupation	Work Phone

Primary Language in Home:	Daytime Caretaker: … Day Care Center … After School Care … School … Baby-sitter … Relative … None	Telephone number of Caretaker 1. 2.

HOUSEHOLD MEMBERS: Does anyone living with you have a chronic medical condition?
… Yes … No If Yes, please explain:

Name	Age	Relationship	Name	Age	Relationship
Name	Age	Relationship	Name	Age	Relationship
Name	Age	Relationship	Name	Age	Relationship

CHILD'S HEALTH HISTORY

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Birth Weight:

Is child adopted?	… Yes	… No
Any complications with pregnancy?	… Yes	… No
Any complications affecting the baby before, during or right after delivery?	… Yes	… No
Has your child missed any regular shots or vaccines?	… Yes	… No

OPERATAIONS AND HOSPITALIZATIONS:

Has the child had any operations?	… Yes	… No
Has the child ever been hospitalized?	… Yes	… No

If yes to either question, please list:

OTHER CONDITIONS OR CONCERNS:

Has your child had trouble with recurrent illnesses?	… Yes	… No
Is your child taking any medications?	… Yes	… No
Do you have any questions about the development of your child?	… Yes	… No
Does your child have any hearing or vision problems or other disabilities?	… Yes	…No
Has your child had any problems with shots/vaccinations?	… Yes	… No
Is your child allergic to foods, drugs, or other materials?	… Yes	… No

(continued)

FAMILY HISTORY

Please CHECK if any of this child's biological relatives or adoptive family (if applicable) have ever had these conditions:

	Biological Family	Adoptive Family
Alcoholism or Drug Abuse	… Yes	… Yes
Anemia	… Yes	… Yes
Asthma, Hay Fever, Allergies, Eczema	… Yes	… Yes
Birth Defects	… Yes	… Yes
Bleeding Tendency, (e.g., Hemophilia)	… Yes	… Yes
High Blood Pressure	… Yes	… Yes
Cancer	… Yes	… Yes
High Cholesterol	… Yes	… Yes
Convulsions or Epilepsy or Seizures	… Yes	… Yes
Deafness / Hearing Loss	… Yes	… Yes
Diabetes	… Yes	… Yes
Glaucoma	… Yes	… Yes
Heart Attack	… Yes	… Yes
Hepatitis	… Yes	… Yes
HIV Disease	… Yes	… Yes
Kidney Problem	… Yes	… Yes
Mental Illness	… Yes	… Yes
Mental Retardation	… Yes	… Yes
Skin Cancer	… Yes	… Yes
Sickle Cell	… Yes	… Yes
Tobacco: Smoke/Chew/Dip	… Yes	… Yes
Weight and/or Eating Problem	… Yes	… Yes
PREVENTION:		
Is your house a smoke-free house?	… Yes	… No
Do you have a working smoke detector?	… Yes	… No
Have you checked the batteries recently?	… Yes	… No
Does your child use a car/toddler seat?	… Yes	… No
Does your child use sun block regularly?	… Yes	… No
Does your child receive regular dental care?	… Yes	… No
Does your home have city water?	… Yes	… No
Does your child use protective head gear during sports/play?	… Yes	… No
ADDITIONAL INFO:		

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