

Indian Crest Pediatrics Medical History Form

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Birth History

Length of pregnancy: _____ weeks

Birth Weight: _____

Delivery type: Vaginal _____

Cesarean section _____

Complications of Pregnancy: _____

Was your child ever breech? YES _____ NO _____

Was your child in the NICU at birth? If so, for how long? _____

Past Medical History

Is the child's health: Good ____ Fair ____ Poor ____?

What allergies does your child have? _____

What medications or vitamins does your child take? _____

Does the child have any developmental or academic problems? Please list _____

Please list any hospitalizations, operations, serious illness or accidents

1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

Does a specialist follow your child for any medical conditions? If yes, please list the condition/specialist

1. _____

2. _____

3. _____

Social History

Please list household occupants: including their name, relationship to patient and date of birth. If your child splits time between families, please list everyone in the other household as well.

Biological/Adoptive parents are: Married ____ Separated ____ Divorced ____ Other: _____

- If divorced please indicate time spent with each parent. Parent 1 ____% Parent 2: ____%

Household 1:

1. Name: _____ Relation to patient _____ Date of birth: _____

2. Name: _____ Relation to patient _____ Date of birth: _____

3. Name: _____ Relation to patient _____ Date of birth: _____

4. Name: _____ Relation to patient _____ Date of birth: _____

5. Name: _____ Relation to patient _____ Date of birth: _____

Household 2:

6. Name: _____ Relation to patient _____ Date of birth: _____

7. Name: _____ Relation to patient _____ Date of birth: _____

8. Name: _____ Relation to patient _____ Date of birth: _____

9. Name: _____ Relation to patient _____ Date of birth: _____

10. Name: _____ Relation to patient _____ Date of birth: _____

Does this patient attend daycare (if not school age)? YES ____ NO ____

Do any family members smoke? YES ____ NO ____ If yes, who? _____

Are there any animals, birds, or reptiles in the home? If yes, what kind? _____

Safety

- Do you have medications/dangerous substances locked away? YES ____ NO ____

- Do you have poison control phone number at home? YES ____ NO ____

- Do you use car/booster seats for all children under 57 inches? YES ____ NO ____ Seatbelts? YES ____ NO ____

- Does your child know how to swim? YES ____ NO ____

- Do you have guns in the home? YES ____ NO ____ If so, how are they stored? _____

- Do you have carbon monoxide and fire detectors at home? YES ____ NO ____

TURN OVER



Patient Name: _____ Date of Birth: _____

Family History: Please write in the first name of individual below and age as they relate to the patient. Place an X in the appropriate boxes that follow. Please add additional details/comments in appropriate box.

	Mother: _____	Father: _____	Sibling 1: _____	Sibling 2: _____	Sibling 3: _____	Sibling 4: _____	Sibling 5: _____	Maternal grandma	Maternal grandpa	Paternal grandma	Paternal grandpa	Other: _____	Other: _____
ADD/ADHD													
Anxiety													
Asthma													
Autism													
Auto Immune Disorder- Type: _____													
Bipolar Disorder													
Bleeding Disorder													
Blood Clots (Leg/Lung)													
Cancer-Type: _____													
Celiac disease													
Depression													
Diabetes													
Drug/Alcohol Abuse													
Eczema													
Food Allergies													
Hay Fever/Allergies													
Hearing loss (Not from infections)													
Heart Attack (< age 50 yo)													
Heart Disease													
High Blood Pressure													
High Cholesterol													
Kidney Failure/Dialysis													
Learning Disabilities													
Migraines													
Schizophrenia													
Seizures													
Stroke													
Sudden Death < age 40													
Thyroid Disease-Type: _____													
Ulcerative Colitis/Crohn's Disease													
Other: _____													
Other: _____													
Other: _____													

Reviewed/Entered by: _____

Date: _____