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____

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:_____