TOTS N TEENS PEDIATRICS

EVERY CHILD IS SPECIAL HERE

PATIENT MEDICAL HISTORY FORM

PATIENT INFORMATION

________________________ First Name ____ M.I. ________________________ Last Name _____/_____/______ Date of Birth

_____/_____/______ Phone # Gender: Male Female _____/_____/_____ Social Security # __________________ Ethnicity

____ E-Mail Address _____/_____/_____ Date

ALLERGIES INFORMATION

Is your child allergic to any medications? Yes No

Name of medication(s) and type(s) of reaction: ______________________________________

____

Does your child have any environment or food allergies? Yes No

Please list allergen and type of reaction: ____

____

Has your child been prescribed an Epi – Pen for a severe allergen reaction? Yes No

FAMILY HISTORY INFORMATION

Has anyone in your family had: ***(Include only parent, grandparent, aunts and uncles)***

Please specify Maternal (mother's side) or Paternal (father's side)

ILLNESS			RELATIONSHIP
High Blood Pressure	YES	NO	
Heart Attack at age < 60	YES	NO	
Stroke at age < 60	YES	NO	
Diabetes	YES	NO	
Allergies	YES	NO	
Asthma	YES	NO	
Cancer	YES	NO	
Mental Illness	YES	NO	

PATIENT MEDICAL HISTORY FORM

Peptic Ulcer	YES NO	
Migraines	YES NO	
High Cholesterol	YES NO	
Seizures	YES NO	
Thyroid Problems	YES NO	

Other: ____

PAST MEDICAL INFORMATION

Check box if your child has or has had any of the following:

Attention Deficit Disorder	YES NO	Recurrent or Frequent Ear Infections	YES NO
Asthma	YES NO	Recurrent or Frequent Strep Throat	YES NO
Severe Allergic Reaction	YES NO	Heart Murmur	YES NO
Urinary Tract Infections	YES NO	Other Significant Medical Conditions	YES NO

Other Medical Conditions: ____

Hospitalizations (***Please Describe***): ____

Surgeries: ____

Serious reactions to Immunizations? YES NO

If yes, which immunization and type of reaction: ____

SOCIAL HISTORY INFORMATION

Do you have Pets? YES NO If yes, what kind? ______________________________

Do you have CITY WATER WELL WATER ? Are there any smokers in the home? YES NO

Is your child in daycare ***(if under age 5)*** ? Name of the Daycare: ______________________________

Name and ages of person(s) living with the patient? ______________________________

____

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MEDICAL INFORMATION

Medications and Dosages is your child on	Medication	Dosage	Times a Day

PREGNANCY AND BIRTH INFORMATION

(Only need to fill out if child is less than 2 months old)

How many weeks pregnant was mother when child was born? _______________

Was mother Group B Strep positive? YES NO If yes, did mother receive antibiotics? YES NO

How many hours prior to delivery did mother's membranes rupture? ________________

Were there any complications with pregnancy or delivery? YES NO

If yes, please explain: ____

Was mother on medications other than prenatal vitamins? YES NO Medicines? ____________________

Type of Delivery? C – SECTION VAGINAL Name of Hospital: _______________________________

If C – Section, give reason for C – Section: ____

At birth, what was baby's weight? __________ Is your baby Bottle – Fed Breast – Fed Both

Did your child have a hearing screen at birth? YES NO DON'T KNOW

If yes, results were NORMAL ABNORMAL

How did you hear about us? ____

____ ____________________ _____/_____/_____

Name of Person Completing the Form Relation to child Date

______________________________________ _____/______/_____

Physician Signature Date

Tel: (919) 362-7155

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