Pediatric Care Physicians

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MEDICAL HISTORY FORM

Child's Name_____Nickname_____

Date of Birth_____ Today's Date_____

Birth History: Hospital:_____

Weight_____Vaginal_____Caesarian_____Gestational age at birth _____

Mother's age at delivery_____Previous pregnancies #_____Previous live births # _____

Complications of pregnancy or delivery_____

Past Medical History:

Problems in infancy _____

Major Illnesses _____

Hospitalizations _____

Surgeries _____

Medication Allergies_____ Food Allergies_____

Current Medications_____

Family Medical History:

Please indicate any family members (parent, sibling, grandparent, aunt, or uncle) with any of the following:

Anemia_____
Asthma_____
Autism _____
Autoimmune disorders _____
Bleeding disorder_____
Cancer, specify type_____
Diabetes before age 50_____
Drug Abuse/ Alcoholism _____
Developmental disorders_____
Genetic disorders_____
Heart Disease before age 50_____
High blood pressure before age 50 _____
High cholesterol before age 50_____
Kidney disease_____
Liver disease_____
Psychiatric illness_____
Seizures_____
Other_____

Problem List (for office use only)	**Labs** (for office use only)