FOREST PEDIATRICS, PA

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Patient Medical History Form

1. Patient & Parent Information

Date:	**Child's Name:**	**Request for Records Transfer Complete?** [ ] Y [ ] N
Previous Physician/Office: **Date of Last Physical:**	**DOB:** _____ / _____ / _____ **Sex:** M / F	
Mother's Name: _____ **Occupation:** _____ **Age:** ____	**Father's Name:** _____ **Occupation:** _____ **Age:** _____	

2. Birth & Neonatal History

Birth Weight: _____
Pregnancy #: _____
Mom's Age at Delivery: _____

Was the baby born on time? [ ] Early [ ] Late
If early, how many weeks gestation? _____

Did the mother have any illness or problems with her pregnancy?
[ ] Y [ ] N *Explain:* _____

During pregnancy, did mother:
- Smoke? [ ] Y [ ] N
- Drink alcohol? [ ] Y [ ] N
- Use drugs or medications? [ ] Y [ ] N

If so, what and when?: _____

Was the delivery: [ ] Vaginal [ ] Cesarean
If Cesarean, why? _____

Did your baby have any problems right after birth?
[ ] Y [ ] N *Explain:* _____

Was initial feeding: [ ] Breast Milk [ ] Formula

Did your baby go home with mother from the hospital?
[ ] Y [ ] N *Explain:* _____

3. Child Medical History

Question / Condition	Yes / No	Explain / Details
Is your child currently on any medication?	[ ] Y [ ] N	_____
Does your child have any serious or chronic illnesses?	[ ] Y [ ] N	_____
Has your child had serious injuries or accidents?	[ ] Y [ ] N	_____
Has your child had any surgery?	[ ] Y [ ] N	_____

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Question / Condition	**Yes / No**	**Explain / Details**
Has your child ever been hospitalized?	[ ] Y [ ] N	_____
Is your child allergic to any medicine or drugs?	[ ] Y [ ] N	_____
Has your child had any reactions to immunizations?	[ ] Y [ ] N	_____

Does Your Child Have, or Ever Had:		
Asthma, recurrent cough, bronchitis, or pneumonia [ ] Y [ ] N	Nasal allergies or eczema [ ] Y [ ] N	Frequent ear infections or sore throats [ ] Y [ ] N
Problems with ears or hearing [ ] Y [ ] N	Problems with eyes, vision, or teeth [ ] Y [ ] N	Frequent headaches or other neurologic problems [ ] Y [ ] N
Frequent abdominal pain [ ] Y [ ] N	Constipation requiring doctor visits [ ] Y [ ] N	Bladder/kidney infection or bed-wetting (after 5 years old) [ ] Y [ ] N
Any heart problem or heart murmur [ ] Y [ ] N	Anemia or bleeding problem [ ] Y [ ] N	Thyroid or other endocrine problem [ ] Y [ ] N
Diabetes [ ] Y [ ] N	ADHD [ ] Y [ ] N	Mental health issues (anxiety, depression) [ ] Y [ ] N
Use of alcohol or drugs [ ] Y [ ] N	Any other medical or mental health issues/problems [ ] Y [ ] N **If so, explain**_____	

Explain/details for any positive answers.

_____

_____

_____

4. Developmental & Special Services

Does your child see any specialists? [ ] Y [ ] N	*If yes, who?* _____ *Reason/Diagnosis:* _____
Has your child ever received Occupational Therapy, Physical Therapy, or Speech Therapy? [ ] Y [ ] N	*Explain:* _____
Is your child in special or resource classes in school? [ ] Y [ ] N	*Explain:* _____
Do you have any other issues or concerns not listed above? _____	

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5. Household Information

Please List Those Living in the Child's Home:

Name	Relationship to Child	DOB
1.		
2.		
3.		
4.		
5.		

Child Care: _____

Smokers in household? [ ] Y [ ] N *Pets in household?* [ ] Y [ ] N

Are there siblings not listed? If so, please list their names and ages and where they live:

_____

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

_____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home?

_____

6. Family Medical History

Have Any Family Members Had The Following? Please specify for both Maternal and Paternal sides (Parents, Siblings, Grandparents, Aunts & Uncles).

Condition	Y / N	Maternal Side	Paternal Side	Additional Notes / Comments
Alcohol/Drug Abuse	[ ]Y [ ]N			
Allergies	[ ]Y [ ]N			
Anesthesia Risk	[ ]Y [ ]N			
Arthritis	[ ]Y [ ]N			
Blood Disease	[ ]Y [ ]N			

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Condition	Y / N	Maternal Side	Paternal Side	Additional Notes / Comments
Cancer	[ ]Y [ ]N			
Diabetes	[ ]Y [ ]N			
Genetic	[ ]Y [ ]N			
Gastrointestinal	[ ]Y [ ]N			
Genitourinary	[ ]Y [ ]N			
Heart	[ ]Y [ ]N			
Hypertension	[ ]Y [ ]N			
Kidney	[ ]Y [ ]N			
Neurologic Diagnosis	[ ]Y [ ]N			
Psychiatry	[ ]Y [ ]N			
Ophthalmology	[ ]Y [ ]N			
Respiratory	[ ]Y [ ]N			
Skin	[ ]Y [ ]N			
Stroke	[ ]Y [ ]N			
Thyroid	[ ]Y [ ]N			
Negative Family History	[ ]Y [ ]N			

Additional Family History / Comments:

_____

_____

Initial Review (Initials/Date): _____