



PEDIATRIC MEDICAL ASSOCIATES, P.C.



CHILD'S MEDICAL HISTORY

DATE _____ CHART# _____ PHYSICIAN _____

CHILD'S NAME: ADOPTED
LAST _____ FIRST _____ BIRTHDATE _____ AGE _____

ANY DIFFICULTIES WITH THIS PREGNANCY: Y N Explain _____

- Smoking Alcohol Medications Infections
- Drug Abuse Toxemia/High Blood Pressure

ANY PROBLEMS WITH LABOR OR DELIVERY OF THIS CHILD: Y N Explain _____

- C-Section Vaginal Delivery Breech Delivery Birth Injury
- Birth Weight _____ Apgar _____ Blood Type _____

NEWBORN PERIOD: No Problems Premature Full Term Jaundice

- Breathing Problems Feeding Problems Infection Sugar Problems
- Temperature Problems Congenital Abnormalities

NUTRITION: Breast Fed to _____ months Bottle Fed to _____ months
 Feeding Problems: Explain _____
 Gained weight well Gained weight slowly Milk intolerance
 Food intolerance: Explain _____

DEVELOPMENT: Indicate Age/Months
 Rolled over _____ Crawled _____ Pulled to stand _____ Walked alone _____
 Single words _____ Two word sentences _____ Gave up Bottle _____
 Toilet trained, daytime _____ Toilet trained, nighttime _____

PLEASE INDICATE WITH A CHECK IF YOUR CHILD HAS OR HAD ANY OF THE FOLLOWING:

- Allergies to Medications _____
- Chronic Medications _____
- Chronic or Long Term Illness _____
- Hospitalizations _____
- Surgical Procedures _____
- Concussion Convulsion w/fever Convulsion w/o fever Cerebral Palsy
- Mental Retardation Asthma Bronchitis Sinusitis Tonsillitis
- Pneumonia Heart Murmur Bladder/Kidney Infections Chickenpox
- Congenital Heart Disease Encephalitis Hepatitis Mononucleosis
- Rubella (three day/German) Mumps Measles (hard/red) Meningitis
- Vision Problems Hearing Problems Speech Problems
- Walking Problems Sleep Problems Other Illnesses _____

IMMUNIZATIONS: Current Y N _____

SIBLINGS: Brothers # _____/Ages _____ Sisters # _____/Ages _____

FOR CHILDREN OVER 5 YEARS, PLEASE INDICATE THE FOLLOWING WITH A CHECK:

- Wets the bed Wets during the day Constipated Soils pants with stool
- Poor school performance Weight loss Overweight Behavior Problems

FAMILY MEDICAL HISTORY:

- Diabetes Hyperthyroidism Hayfever Asthma Epilepsy AIDS
- Emphysema Cystic Fibrosis Seizure w/fever Heart Defects Drug Use
- Mental Retardation High Cholesterol Kidney Disease Alcoholism Allergies
- Migraines Liver Disease Bone/Joint Disease Bleeding Problems

PETS: _____ **PARENTS:** Married Separated Divorced Widowed Single

Additional information about family or home that may be helpful in caring for your child:
