Patient Medical History

Date Completed:_____

Patient Name:_____ Drug Allergies:_____

Birth Date_____ Hospital/City: _____ Ob/Gyn:_____

Pregnancy Problems:_____ Tobacco: Y N Alcohol: Y N Drugs: Y N

Birth Weight: _____ Birth Problems: _____

Feeding: Breast:___ Formula:___(type:_____) Previous Pediatrician City:_____

Medical Problems: (List all major illnesses and any recent or ongoing medical problems, including date of diagnosis.)

_____

_____

_____

Hospitalizations/Surgeries:

Date Hospital/City Reason

_____

_____

_____

Medications: (List all current prescriptions and over-the-counter medications.)

_____

_____

Family History: Does any family member (sibling, parent, grandparent, uncle, aunt) have the following?

		Who?
ASTHMA	Y N	_____
ALLERGIES	Y N	_____
CANCER	Y N	_____
CYSTIC FIBROSIS	Y N	_____
DIABETES	Y N	_____
HIGH CHOLESTEROL	Y N	_____
HEART DISEASE BEFORE 50	Y N	_____
STROKE BEFORE 50	Y N	_____
HIGH BLOOD PRESSURE	Y N	_____
MIGRAINE HEADACHES	Y N	_____
KIDNEY PROBLEMS	Y N	_____
SEIZURES/EPILEPSY	Y N	_____
DEVELOPMENTAL/LEARNING PROBLEMS	Y N	_____
PSYCHIATRIC PROBLEMS	Y N	_____
SMOKES	Y N	_____
ALCOHOL ABUSE	Y N	_____
ILLEGAL DRUG USE	Y N	_____

Social History:

Family's primary Language: ___English __Spanish Other:_____ Interpreter Needed?: Y N