ADVANCED PEDIATRIC ASSOCIATES
Patient Medical History Form

Date	Child's Name	Nickname	DOB	M F

Previous Physician/Office	Request for Records Transfer Complete Y N	Date of Last Physical

Mother's Name	Occupation	Age	Father's Name	Occupation	Age

Birth History

Birth weight _____ Preg # _____ Mom's age _____
Was the baby born on time?_____ Early?_____ Late? _____
If early, how many weeks gestation? _____
Did 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
What _____ 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 _____

Current and Past History

Is your child currently on any medication?	☐ Y ☐ N	Explain _____
Does your child have any serious or chronic illnesses?	☐ Y ☐ N	Explain _____
Has your child had serious injuries or accidents?	☐ Y ☐ N	Explain _____
Has your child had any surgery?	☐ Y ☐ N	Explain _____
Has your child ever been hospitalized?	☐ Y ☐ N	Explain _____
Is your child allergic to any medicine or drugs?	☐ Y ☐ N	Explain _____
Has your child had any reactions to immunizations?	☐ Y ☐ N	Explain _____
Does Your Child Have, or Ever Had:		
Asthma, recurrent cough, bronchitis, or pneumonia	☐ Y ☐ N	Explain _____
Nasal allergies or eczema	☐ Y ☐ N	Explain _____
Frequent ear infections or sore throats	☐ Y ☐ N	Explain _____
Problems with ears or hearing	☐ Y ☐ N	Explain _____
Problems with eyes, vision, or teeth	☐ Y ☐ N	Explain _____
Frequent headaches or other neurologic problems	☐ Y ☐ N	Explain _____
Frequent abdominal pain	☐ Y ☐ N	Explain _____
Constipation requiring doctor visits	☐ Y ☐ N	Explain _____
Bladder/kidney infection or bed-wetting (after 5 years old)	☐ Y ☐ N	Explain _____
Any heart problem or heart murmur	☐ Y ☐ N	Explain _____
Anemia or bleeding problem	☐ Y ☐ N	Explain _____
Thyroid or other endocrine problem	☐ Y ☐ N	Explain _____
Diabetes	☐ Y ☐ N	Explain _____
ADHD	☐ Y ☐ N	Explain _____
Mental health issues (anxiety, depression)	☐ Y ☐ N	Explain _____
Use of alcohol or drugs	☐ Y ☐ N	Explain _____

Any other medical or mental health issues/problems _____

Does your child see any specialists? ☐ Y ☐ N If yes, Who?_____
For what reason or diagnosis? _____

Has your child ever received Occupational Therapy, Physical Therapy, 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? _____

Household Information

Please List All Those Living in the Child's Home

Name	Relationship to Child	DOB

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? _____

_____

Family Medical History (Parents, Siblings, Grandparents, Aunts & Uncles)

Have Any Family Members Had The following:

Alcohol/Drug Abuse	☐ Y ☐ N	Who_____	Comments_____
Allergies	☐ Y ☐ N	Who_____	Comments_____
Anesthesia Risk	☐ Y ☐ N	Who_____	Comments_____
Arthritis	☐ Y ☐ N	Who_____	Comments_____
Blood Disease	☐ Y ☐ N	Who_____	Comments_____
Cancer	☐ Y ☐ N	Who_____	Comments_____
Diabetes	☐ Y ☐ N	Who_____	Comments_____
Genetic	☐ Y ☐ N	Who_____	Comments_____
Gastroenteritis	☐ Y ☐ N	Who_____	Comments_____
Genitourinary	☐ Y ☐ N	Who_____	Comments_____
Heart	☐ Y ☐ N	Who_____	Comments_____
Hypertension	☐ Y ☐ N	Who_____	Comments_____
Lipids	☐ Y ☐ N	Who_____	Comments_____
Neurologic Diagnosis	☐ Y ☐ N	Who_____	Comments_____
Psychiatry	☐ Y ☐ N	Who_____	Comments_____
Ophthalmology	☐ Y ☐ N	Who_____	Comments_____
Respiratory	☐ Y ☐ N	Who_____	Comments_____
Skin	☐ Y ☐ N	Who_____	Comments_____
Stroke	☐ Y ☐ N	Who_____	Comments_____
Thyroid	☐ Y ☐ N	Who_____	Comments_____
Negative Family History	☐ Y ☐ N	Who_____	Comments_____

Additional Family History/Comments _____

_____

_____

Initial Review (initials/date):