San Gabriel Pediatrics 1524 Leander Rd, Georgetown, TX 78628 (512) 863-7586

Medical History

Patient's name:______________________________________ Date of birth:____________________

Reason for visit:____

Current medications:____

Allergies to medication: _____________________________ Foods:____________________________

Past Medical History - Any diseases or problems with any of the following?

Eyes__________________ Heart__________________ Muscle or Bone____________________

Ears/Nose/Throat_________________ Stomach or Intestines____________ Convulsions___________

Lung / Respiratory________________ Kidneys______________ Skin________________________

Past hospitalizations: Reason ____ ____/__________
Age date

Operations / Poisonings / Serious injuries (broken bones):_________________________________

____

Mother's pregnancy history of this child: Check ___If adopted. Length of pregnancy: ______ wks.

Incident	Yes	Month	Type or reason
Infections			
Bleeding			
Medications			
Injuries			
Exposures to x-ray			
Drugs			
Other			

Delivery history: Information on this infant BREAST or BOTTLE (Circle one)

Birth wt:__________ Forceps used?_____ Cesarean section?_____ Reason________________

Any problems with: _____Bleeding Delay in cry or breathing?______________________________

Was baby given oxygen?______ If so, how long?____________ Did baby have jaundice?_______

Other problems:____

APGAR scores__________ Mother's blood type____________ Baby's blood type_____________

Age that child: Rolled over________ Sitting________ Walking________ Talking________

Using sentences________ Toilet trained________

Average grades in school_____ Any grades failed?____

Any problems with: Speech?_____________ Vision?_____________ Hearing?_______________

Any history or concern for emotional problems?____

Have menstrual periods begun?_____________ At what age?_____________________

San Gabriel Pediatrics **Medical history continued**

Immunization: Are immunizations up-to-date?____________________________

Please provide a copy of your child's current immunization record.

Environmental history:

Do you have city or well water?_______________

Is the patient in contact with animals or pets?______ If so, what kind?________________________

Do any family members smoke?______

Is there exposure to toxins such as insecticides, fumes, etc.?________________________________

Has the patient or a family member traveled outside the United States.?__________

If so, When?_________________ Where?_______________________________________

Social history:

Father's occupation:________________________ Mother's occupation:________________________

Are parents: Married_____ Deceased_____ Separated_____ Divorced_____ Remarried_____ Single_____

Child lives with:__________________________________ ________________________________
Name Relationship

	Name	Ages	Medical problems
Father			
Mother			
Brother(s)			
Sister(s)			

Relative's History: Do any aunts, uncles, cousins, grandparents have any of the following diseases?

Disease	Yes	Relation to patient
Deafness		
Eye disease		
TB or other lung disease		
Asthma		
Endocrine (hormone) problems		
Diabetes		
Anemia		
Bleeding problems		
Kidney disease		
Hypertension		
History of Heart attack or Stroke under the age of 50		
Muscle or Bone disease		
Convulsions or Epilepsy		
Birth defects / Genetic problems		
Cholesterol problems		
Other		

Completed by:_________________________________ Relationship to patient:_______________ Date:_________
Signature MM / DD / YY