**Georgetown Kids** 3613 Williams Dr, Suite 801, Georgetown, TX 78628 512-930-9101

# 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?_____

**Georgetown Kids** **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