

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