Pediatric Medical History-Cereal City Pediatrics

***Please fill out this history form so that we may properly begin your child's electronic medical record. Also, if your child has received shots elsewhere, please let us know.**

Child's Name:_____**Date of Birth**_____Current Age:_____Allergies:_____
Who lives in the home?_____
Does anybody smoke (indoors or outdoors)?_____
Are there guns in the home?_____If yes, are they locked up?_____

Newborn History: (please fill this section out if your child is under the age of 3 years)

*If you have a copy of the hospital discharge form, you do not need to fill this section out, simply hand us that.

Place of Birth:_____Full Term or Preterm (circle one) Gest Age_____
For Preterm infants, was Synagis recommended: Yes No Unsure

Birth Weight:_____ Birth Height:_____ Birth Head Size:_____ Discharge Weight_____

Current Medications (Including Vitamins, herbal remedies):_____
_____

Past Medical History:

Inpatient Hospitalizations:_____
Surgeries:_____
Any significant or chronic health problems (please specify): _____
_____

Family History:

Please indicate M-(Mom), D-(Dad), MGM/MGF-(Maternal Grandmother/Maternal Grandfather), PGM/PGF (Paternal Grandmother/Paternal Grandfather), Sister/Brother (please specify who), Aunt/Uncle (**please specify if Maternal or Paternal Aunt/Uncle**), O-Other (specify who)

_____Allergies
_____Asthma/Lung Disease
_____Bleeding Disorder
_____Diabetes
_____Other Endocrine Disorder
_____Ear or Hearing Problem
_____Heart disease/Heart condition
_____High Blood Pressure
_____High Cholesterol
_____Kidney Disease
_____Liver Disease
_____Seizure or Epilepsy
_____Tuberculosis
_____Mental Illness
_____Anemia
_____Bed-Wetting (after 10 years of age)
_____Cancer
_____Developmental Disorder/delay or Neurologic Disorder
_____Migraines
_____Heart disease <50 or sudden death of unexplained causes
_____Immune Problems, recurrent infections, or HIV/AIDS
_____ Gastrointestinal (stomach or digestive system) problem
_____Vision impairment/eye disorder
_____Musculoskeletal/Bone/Joint Disease

Please explain, in detail, your marked items from family history above

_____
_____
_____
_____

Signature of Person completing form_____Date_____

Relationship to Child_____