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 <u>ONLY</u> if your child is under the age of 2 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:

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

Family History:

Please indicate M-(Mom), D-(Dad), GM/GF-(Grandmother/Grandfather), S-(Sibling-specify who), O-(other)

_____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
_____Heart disease <50 or sudden death of unexplained causes
_____Immune Problems, recurrent infections, or HIV/AIDS
_____Other Gastrointestinal (stomach or digestive system) problem
_____Vision impairment/eye disorder
_____Musculoskeletal/Bone/Joint Disease

Please explain all of the above (please remember to specify child's name if one of your other children has one of these conditions): _____
_____
_____

Signature of Person completing form_____ Date_____
Relationship to Child _____