PEDIATRIC MEDICINE **PATIENT MEDICAL HISTORY**

ALEXANDER PEDIATRICS, LLC

NAME: _____ DOB: _____

PERINATAL HISTORY:

MOTHER'S AGE: _____ PREGNANCIES: _____ LIVE BIRTHS: _____

PREGNANCY COMPLICATIONS: NO/YES: _____ _____

EDC: _____ FULL TERM/PRE-TERM BIRTH WT. _____ LBS. _____ OZ.

SPONTANEOUS: _____ ASSISTED: NO/YES FORCEPS/VACUUM C-SECTION: _____

NEONATAL HISTORY:

FETAL DISTRESS: _____ SEPSIS: _____ JAUNDICE: _____ RDS: _____

PAST MEDICAL HISTORY:

WALKED AT: _____ TALKED AT: _____

( ) ALLERGIES
( ) ANEMIA
( ) ASTHMA
( ) BEHAVIOR PROBLEM
( ) BEDWETTING
( ) BONE/JOINT PROBLEMS
( ) CANCER
( ) EAR INFECTIONS
( ) EYE PROBLEMS
( ) FOOD INTOLERANCE
( ) GI: CONSTIPATION/DIARRHEA/VOMITING
( ) GENITO/URINARY PROBLEMS
( ) HEADACHES
( ) HEART PROBLEMS
( ) KIDNEY/BLADDER PROBLEMS
( ) MENTAL ILLNESSES
( ) POISONING
( ) RESPIRATORY ILLNESSES
( ) SCHOOL PROBLEMS
( ) OTHER: _____

( ) SURGERY TYPE: _____ DATE: _____ HOSPITALIZATION: Y/N

***ALLERGIC TO: MEDICATIONS:** N/Y _____ **FOOD:** N/Y _____ **OTHER:** _____

DAILY MEDICATIONS: NONE/Y _____

FAMILY HISTORY	MOTHER	FATHER	MGP	PGP
ANEMIA	_____	_____	_____	_____
ASTHMA/ALLERGIES	_____	_____	_____	_____
BIRTH DEFECT	_____	_____	_____	_____
CANCER	_____	_____	_____	_____
DIABETES	_____	_____	_____	_____
HEART DISEASE	_____	_____	_____	_____
HYPERTENSION	_____	_____	_____	_____
KIDNEY/LIVER	_____	_____	_____	_____
MENTAL RETARDATION	_____	_____	_____	_____
SEIZURES	_____	_____	_____	_____

Siblings: (Name/ DOB)

PREVIOUS PCP: _____
Date of last check up:_____
Date of last dental screening: _____

Social History:
Do you live in a house, apartment, mobile home, or other?_____
Are there any smokers at home? Yes/No