The Pediatric Specialists Medical Group

NEW PATIENT MEDICAL HISTORY-6 MONTHS & OLDER

- THIS FORM MUST BE COMPLETED PRIOR TO YOUR FIRST OFFICE VISIT.
- ***WE DO REQUIRE IMMUNIZATION RECORDS BEFORE WE CAN ADMINISTER VACCINES.***

The following is very important to your child's health. Please complete it accurately and completely.

Child's First Name:_____ **Last Name:**_____

Date of Birth:_____ Place of Birth:_____

Mother's Name:_____ Father's Name:_____

Parent's Marital Status: Single Married Divorced Separated Widowed

Biological Mother: YES NO Biological Father: YES NO

Adoption YES NO Foster Child: YES NO Surrogate/Other: YES NO

BIRTH HISTORY

Birth Weight:_____ Vaginal or C-Section

Full Term Premature-weeks:_____ Late:_____

Problems at Birth?_____

Problems during Pregnancy?_____

DEVELOPMENTAL HISTORY

Are you concerned about your child's physical development?
Are you concerned about your child's attention span?
Has he/she failed or repeated a grade?
How is your child's behavior in school?
What kind of grades does he/she make in subjects?
Is he/she is special or resource classes?

When did your child: Sit Up_____ Crawl_____ Walk_____

First Sentence at age_____

Toilet trained at age_____

ALLERGIES	**NO**	**YES-Explain**
My Child is Allergic to Drugs?		
If you answered YES-what is your child allergic to:		
Penicillin(Amoxicillin, Augmentin)		
Cephalosporins (Omnicef, Keflex, Rocephin, Ceclor, Suprax)		
Sulpha (Septra, Bactrim)		
Zithromax/Erythromycin		
Other Antibiotics or Medications? What Reactions?		
My Child is Allergic to Foods?		
Peanuts or Nuts		
Milk		
Eggs		
Seafood		
Other Foods		
Bees/Wasps		
Indoor Allergens(pets, molds, dust)		
Outdoor Allergens (trees, weeds, pollens)		
Latex		
Other Allergies:		

PATIENT-PAST MEDICAL HISTORY	NO	YES-Explain
Serious accidents or injuries		
Surgeries		
Hospitalizations		
Chicken Pox	Age?	
Frequent Ear Infections		
Frequent sore throats or tonsillitis		
Other infection illnesses		
Allergic rhinitis or other allergy		
Asthma, bronchitis, bronchiolitis, pneumonia, croup		
Heart problems or murmur		
Abdominal pain/reflux		
Constipation requiring doctor visits		
Bladder or Kidney infection or other urologic problem		
Bed wetting after age 5		
Eye conditions/ wears corrective lenses		
Problems with ears or hearing		
Chronic or recurrent skin problems/acne		
Anemia or bleeding problem		
Past blood transfusion		
Frequent headaches/migraines		
Convulsions/ seizures, or past concussions?		
Behavioral concerns		
Developmental delays-ADD/ ADHD/other neurologic disorder		
Orthopedic problems		
Diabetes		
Thyroid, or other endocrine problems		
If female, have periods started?		
Use of alcohol or drugs		
Emotional or mental health concerns		
Other significant issues;		

FAMILY MEDICAL HISTORY	NO	YES	If YES-explain
Nasal Allergies or Other			
Asthma/Lung disease			
Heart Disease or Condition			
High Blood Pressure			
High Cholesterol			
Diabetes			
Cancer			
Anemia			
Bleeding Disorder			
Epilepsy or Seizures			
Mental Retardation or Developmental Delay?			
Neurologic Disorders incl. ADD/ADHD			
Liver Disease			
Other GI issues			
kidney Disease			
Bed Wetting (after age 10)			
Hearing Impairment			
Vision/Eye Disorders			
Immune Problem, Recurrent			
Infections or HIV/AIDS?			
Alcohol Abuse			
Drug Abuse			
Mental Illness			
Tuberculosis			

SOCIAL HISTORY			
Lives with Intact Family?			
Non-Intact Custody Status?			
Visitation Status with non-custodial parent			
Siblings?			
Pets?			
Smokers in the home			
Guns in the Home?			
Guns locked & kept separate from Ammunition?			