Children's of Alabama®

MEDICAL HISTORY

PLEASE RETURN THIS FORM TO ONE OF THE FOLLOWING LOCATIONS:

Pediatrics East - Deerfoot
6729 Deerfoot Parkway
Pinson, AL 35126
PHONE: 205-681-5377
FAX: 205-212-7102

Pediatrics East - Trussville
520 Simmons Dr
Trussville, Al 35173
PHONE: 205-661-4680
FAX: 205-212-7102

PATIENT INFORMATION

PATIENT'S FULL NAME (CHILD)	DATE OF BIRTH	PREFERRED NAME (NICKNAME)
MOTHER'S NAME	AGE	OCCUPATION
FATHER'S NAME	AGE	OCCUPATION
LIST ALL OTHERS LIVING WITH THIS PATIENT (NAME, AGE. RELATION):		

Social History

Are mother and father (check one): Married ☐ Divorced ☐ Separated ☐

If separated or divorced, who has custody? _____

Does anyone other than a parent have custody? Y ☐ N ☐

If yes, please specify and relationship to the child: _____

Does anyone in the house smoke? Y ☐ N ☐

Does the child attend daycare? Y ☐ N ☐

Birth History (may skip if completed in the past)

Was your baby full term (37 weeks or greater)? Y ☐ N ☐

How many weeks?_____

Type of delivery (check one)? C-section ☐ Vaginal ☐

Reason for C-section? _____

Any problems in the hospital or the baby's first few months of life (jaundice, infection, breathing problems, NICU admission)? _____

_____

Past Medical History

Previous physician of source of care: _____

Does your child see a dentist? Y ☐ N ☐

Has your child ever been hospitalized? Y ☐ N ☐

For what? _____

_____

Has your child ever had surgery? Y ☐ N ☐

What type? _____

_____

What medications does your child take regularly? _____

_____

_____

_____

Any allergies or reactions to medications? _____

_____

Does your child smoke or use tobacco? Y ☐ N ☐

Does your child use alcohol or drugs? Y ☐ N ☐

Has your child had a history of any of the following conditions? (please circle)

☐ Asthma/Wheezing	☐ Allergies	☐ Anemia
☐ Heart Problems/Murmur	☐ Kidney Problems	☐ Pneumonia
☐ Chicken pox	☐ Sickle Cell Disease or Trait	☐ HIV/AIDS
☐ Immune System Problems	☐ Eczema	☐ Diabetes
☐ Seizure Disorder	☐ Behavior Problems	☐ ADD/ADHD
☐ Developmental Delay	☐ Cerebral Palsy	☐ Reflux
☐ Migraines	☐ Neurological Problems	☐ Food Allergy
☐ Vision Problems	☐ Hearing Problems	☐ Depression
☐ Bleeding Problems	☐ Urinary Tract Infection	☐ Broken Bones
☐ Rash or skin condition	☐ Hepatitis	☐ Tuberculosis

Has your child received care outside of the practice? Y ☐ N ☐

Does your child see any other physician on a regular basis? If so, please name the physician and provide the last date seen._____

Please list any other medical problems: _____

_____

_____

Family History

Please check if a parent, sibling, grandparent, aunt or uncle have any of the following

☐ Anemia ☐ Asthma ☐ Allergies ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems ☐ HIV/AIDS ☐ Hepatitis ☐ Breathing Problems
☐ ADHD/ADD ☐ Depression ☐ Schizophrenia ☐ Alcoholism
☐ Drug Abuse ☐ Tuberculosis ☐ Cancer ☐ Sickle Cell Diseases or Trait
☐ Cystic Fibrosis ☐ Stomach or GI Problems ☐ Mental Illness
☐ Deafness ☐ Vision Problems

Any other medical problems in the family: _____

_____

Lead Screening (Age 5 years and under):

Has your child ever been diagnosed with and elevated lead level?

Y ☐ N ☐ Unsure ☐

Does your child have a sibling or playmate who has or had lead poisoning?

Y ☐ N ☐ Unsure ☐

Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has in the last 6 months been renovated or remodeled?

Y ☐ N ☐ Unsure ☐

Does your child live in or regularly visit a house or child care facility built before 1950?

Y ☐ N ☐ Unsure ☐

Tuberculosis Screening

Has your child or a family member or contact ever had a positive TB test?

Y ☐ N ☐ Unsure ☐ Who? _____

Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?

Y ☐ N ☐ Unsure ☐

Has your child traveled to or had contact with people from a county with a high risk of tuberculosis (same as above)?

Y ☐ N ☐ Unsure ☐

Cholesterol/Heart Disease Screening (Age 2 years and Up)

Has your child ever been diagnosed with elevated cholesterol?

Y ☐ N ☐ Unsure ☐

Does your child have parents or grandparents with stroke or heart disease before age 55 for men or 65 for women?

Y ☐ N ☐ Unsure ☐

Does your child have a parent with blood cholesterol greater than 240 or take cholesterol medication?

Y ☐ N ☐ Unsure ☐