# *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: 205-638-7102

**Pediatrics East - Trussville**
520 Simmons Dr
Trussville, Al 35173
PHONE: 205-661-4680
FAX: 205-638-7102

## 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 check)

| | | |
|---|---|---|
| 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