Over the Mountain Pediatrics

Medical History Form

Patient's Full Name (child)	Date of Birth	Preferred Name (nickname)
Mother's Name	Date of Birth	Occupation
Father's Name	Date of Birth	Occupation

List all others living in home – name, age, relation:

Social History (please circle below)

Are mother and father: Married Divorced Separated Engaged Remarried

If separated or divorced, who has custody?

Does anyone other than the parent have custody? YES NO

If yes, please specify: _____

Does anyone in the house smoke? YES NO

Does this child attend daycare? YES NO

Birth History

Full term – 37 weeks or greater? YES NO

How many weeks? _____

Type of delivery? (circle one) Vaginal C-Section

Reason for C-section? _____

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

Cholesterol Screening (please circle below)

Has your child ever had a high cholesterol? YES NO UNSURE

Parents or Grandparents with stroke or heart disease before 55 for men and 65 for women? YES NO UNSURE

Parent with cholesterol greater than 240 or on cholesterol meds? YES NO UNSURE

Past Medical History

Prior physician or source of care: _____

Does your child see a dentist? YES NO

Has your child been hospitalized? YES NO

If so, why? _____

Has your child ever had surgery? YES NO

If so, what for? _____

What medications does your child take regularly? _____

Any allergies or reactions to medicines or food? YES NO

If so, what kind of reaction (rash, breathing problems)_____

Does your child smoke or use tobacco? YES NO

Does your child use alcohol or drugs? YES NO

Past Medical History

Has your child ever had a history of any of the following? If so, please add year of onset in space provided.

ADD/ADHD_____
Allergies_____
Anemia_____
Asthma/Wheezing_____
Behavior Problems_____
Bleeding Problems_____
Broken Bones_____
Cerebral Palsy_____
Chicken Pox_____
Depression_____
Developmental Delay_____
Diabetes_____
Eczema_____
Hearing Problems_____
Heart Problems_____
Heart Murmur_____
HIV/AIDS_____
Immunity Problems_____
Kidney Problems_____
Migraines_____
Neuro. Problems_____
Pneumonia_____
GI Reflux_____
Seizure Disorder_____
Sickle Cell Disease_____
Sickle Cell Trait_____
UTI_____
Vision Problems_____

If you have had any of the problems above please be more specific (what kind of heart problems, which bones were broken, etc.)_____

Family History

If a parent, brother, sister, maternal/paternal grandparent, aunt, or uncle have any of the following, please **INDICATE <u>WHO</u>** in the space provided. Please also indicate what type/kind when prompted to do so.

ADD/ADHD_____
Alcoholism_____
Allergies_____
Anemia_____
Asthma_____
Breathing Problems_____
Cancer_____
Cystic Fibrosis_____
Depression_____
Diabetes (type?)_____
Drug Abuse_____
Hearing Loss_____
Heart Problems_____
Hepatitis (type?)_____
High Blood Pressure_____
HIV/AIDS_____
Schizophrenia_____
Sickle Cell Disease_____
Sickle Cell Trait_____
Stomach/GI Problems(type/kind)_____
Tuberculosis_____
Vision Problems_____

INDICATE <u>WHO</u> in the space provided above.