Children's of Alabama

***Over the Mountain Pediatrics***
***3300 Cahaba Road, Suite 102***
***Birmingham, AL 35223***

# MEDICAL HISTORY

Patient Information

| **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
If separated or divorced, who has custody? _____
Does anyone other than a parent have custody? Y N
If yes, please specify. _____
Does anyone in the house smoke? Y N
Does this child attend daycare? Y N

**Birth History**
Full term - 37 weeks or greater? Y N
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)_____

**Past Medical History**
Prior physician or source of care: _____
Does your child see a dentist? Y N
Has your child been hospitalized? Y N
For what? _____
_____
Has your child ever had surgery? Y N
For what? _____
What medications does your child take regularly?
_____
_____
_____
Any allergies or reactions to medicines or foods?
_____
Does your child smoke or use tobacco? Y N
Does your child use alcohol or drugs? Y N

**Past Medical History (**please circle below)
Has your child ever had a history of any of the following?

| | |
|---|---|
| Asthma/wheezing | Allergies |
| Anemia | Heart problem/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 |
| Vision problems | Hearing problems |
| Depression | Bleeding problems |
| Urinary Tract Infection | Broken bones |

Please list any other medical problems and/or explain above:_____
_____

**Family History**
Please circle below if a parent, sibling, grandparent, aunt or uncle have any of the following conditions:
Anemia, asthma, allergies, diabetes, high blood pressure, heart problems, HIV/AIDS, hepatitis, breathing problems, ADD/ADHD, depression, schizophrenia, alcoholism, drug abuse, tuberculosis, cancer, sickle cell disease or trait, cystic fibrosis, stomach or GI problems, depression, mental illness, hearing loss, vision problems.
Please elaborate on who has condition and any other family history. _____
_____

**Cholesterol Screening** (u = unsure)
Has your child ever had a high cholesterol? Y N U
Parents or Grandparents with stroke or heart disease before 55 for men and 65 for women? Y N U
Parent with cholesterol greater than 240 or on cholesterol