



Children's
of Alabama

MEDICAL HISTORY

PEDIATRICS EAST	
520 Simmons Drive Trussville, AL 35173	6729 Deerfoot Parkway Birmingham, AL 35126

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 (circle 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 (circle 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 or 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 circle 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, ADHD/ADD, depression, schizophrenia, alcoholism, drug abuse, tuberculosis, cancer, sickle cell disease 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