GEORGE MED-PEDS ASSOCIATES, P.C.
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CHILD HEALTH HISTORY

PATIENT NAME: ______________________ **AGE:** ______ **TODAY'S DATE:** ____/____/____

I. BIRTH HISTORY

Birth Weight:_______________________ Length:_______________________ Place:_________________________

During the pregnancy did the mother see a doctor on a regular basis? **O Yes O No**

During the pregnancy, did the mother: (If yes, please explain) **EXPLANATION**

Have any medical problems? **O Yes O No** ____
Have a venereal disease? **O Yes O No** ____
Smoke Tobacco? **O Yes O No** ____
Have hepatitis? **O Yes O No** ____
Use any medications? **O Yes O No** ____
Use alcohol or other drugs? **O Yes O No** ____
Have problems with labor/delivery? **O Yes O No** ____
Type of delivery **O Vaginal O C-Section**
How long did the baby stay in the hospital after birth? ____

II. CHILD'S PAST MEDICAL HISTORY

Is the child's general health: **O Good O Fair O Poor** **LIST**
Does the child have any allergies? **O Yes O No** ____
Is the child taking any medications? **O Yes O No** ____
Please list any hospitalizations, operations, serious illnesses or accidents with dates:
____ Date: ______________________
____ Date: ______________________

Who takes care of this child? ____

III. HOUSEHOLD INFORMATION

(Please list all people in household)

	NAME	AGE
Father		
Mother		
Other		
Other		
Other		
Other		

IV. FAMILY HISTORY

Have any of the child's brothers or sisters died? **O Yes O No** (If yes, give age at death and cause:)
____

Have any of the child's blood relatives had the following diseases? (If yes, list family member and age of onset:)

		FAMILY MEMBER			**FAMILY MEMBER**
Heart Disease	**O Yes O No**	__________________	Cancer	**O Yes O No**	___________________
Tuberculosis	**O Yes O No**	__________________	Diabetes	**O Yes O No**	___________________
High Blood Pressure	**O Yes O No**	__________________	Mental / Emotional Problems	**O Yes O No**	___________________
Kidney Disease	**O Yes O No**	__________________	Sickle Cell Disease	**O Yes O No**	___________________
Allergies	**O Yes O No**	__________________	Seizures	**O Yes O No**	___________________
Asthma	**O Yes O No**	__________________	Others (list):		________________________________

____ ____
Reviewed by Physician Date of Review