Village Pediatrics - Medical History Form

PATIENT NAME:	DATE OF BIRTH:
DRUG ALLERGIES:	

BIRTH HISTORY

Gestational Age:	Birth Weight:	Discharge Weight:
Vaginal/C-Section:	Reason for C-Section:	Discharge Date:
Name of OB/GYN/Birth Hospital:		
Complications during pregnancy/delivery/nursery stay:		

PAST MEDICAL HISTORY: Please check all that apply and provide detail

Serious Injuries/Accidents	
Surgeries	
Hospitalizations	
Food Allergies	
Seasonal Allergies	
Asthma/Wheezing	
Heart Condition	
Constipation	
Urinary Tract Infection	
Vision Problems	
Hearing Impairment	
Eczema	
Anemia	
Bleeding disorder	
Migraines	
Seizure disorder	
Concussion	
ADHD	
Developmental Delays	
Depression/Anxiety/Bipolar Disorder	
Diabetes	
Thyroid Disorder	
Other	

Family History: Does anyone in your family have the following medical conditions?

(MGM: maternal grandmother, MGF: maternal grandfather, PGM: paternal grandmother, PGF: paternal grandfather, Sib: siblings, Other: maternal or paternal aunts/uncles/cousins – please specify)

Medical Condition	**Mom**	**Dad**	**MGM**	**MGF**	**PGM**	**PGF**	**Sib**	**Other**	**Notes**
Food Allergy									
Asthma									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Diabetes (type I or II)									
Cancer (type)									
Anemia									
Bleeding Disorder									
Seizure Disorder									
Developmental Delay									
Migraines									
ADHD									
GI Condition (Crohn's, Ulcerative Colitis, Celiac)									
Kidney Disease									
Hearing Impairment									
Alcohol Abuse									
Drug Abuse									
Depression/Anxiety									
Bipolar Disorder									
Thyroid Disease									
Other									

SOCIAL HISTORY

Lives at home with:	Number of siblings:	
Visitation of non-custodial parent:		
Pets?	Yes No Type?	
Smokers in the home?	Yes No Smoke Indoors?	
Guns in the home?	Yes No Decline to Answer	
Guns locked and separate from ammo?	Yes No	
Parents Marital Status:	Married Divorced Single Other:	
Mom's occupation:		Dad's occupation: