CARTERSVILLE PEDIATRIC ASSOCIATES, P.C.
PATIENT HISTORY FORM

Patient's Name: _____ Date of Birth: _____
Birth Weight: _____ Birth Height: _____

Pregnancy History

1. Delivery Method: □ Vaginal □ C-Section Breech Yes___ No____
2. Baby was: □ Full Term □ Premature
3. List any illnesses Mother had during pregnancy: _____
   _____
4. List any medications Mother took during pregnancy (prescription & non-prescription): _____
   _____
5. List any problems during labor & delivery: _____
   _____
6. Did baby go home with Mother? □ Yes □ No If no, why? _____
   _____
7. List any problems that occurred in the first month of birth? _____
   _____

Child's History

1. List any **drug** allergies the child has: _____
2. List any **other** allergies the child has:_____
3. List all of the child's current medications: _____
4. List any significant injury or illness your child has had: _____
   _____
5. List any hospitalizations or surgeries the child has had: _____
   _____
6. List any other significant health concerns the provider should be aware of : _____
   _____

Family History

Has anyone in the child's immediate family had any of the following (Check all that apply):

- ○ Alcohol/Drug Use
- ○ Asthma/ Allergies
- ○ Behavioral Problems
- ○ Birth Defects
- ○ Blood Disorders/Sickle Cell
- ○ Cancer
- ○ Diabetes
- ○ Hearing/Vision Problems
- ○ Heart Disease/High Blood Pressure
- ○ Seizures/Epilepsy
- ○ Other: _____

Parent/Guardian Signature: _____ Date: _____

Internal Use Only

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