BARROW PEDIATRICS – Medical History *(Please Print)*

Name:_____ DOB:_____

Birth History (Circle all that apply):

Delivery: Vaginal? Cesarean? Due to: _____ Birth Weight: _____

Was this child premature? Yes No
If yes, how many weeks? _____

Were there problems with this child's delivery? Yes No
If yes, please list:

Did this child need special treatment while in the hospital such as oxygen, transfusions, lights? Yes No

Was (is) this child breast fed? Yes No

Did (does) this child have any problems with breast feeding or formula feeding? Yes No

Social History (Circle all that apply):

Parents' status: Married Single Divorced Separated
Siblings – please list: _____
Is child currently enrolled in daycare or school? Yes No

Medical History (Circle all that apply):

Hospitalizations? None Yes - list:

Are immunizations up to date? Yes No Unsure

Surgeries? None Yes - list:

Has child ever seen a specialist? Yes No
If yes, which specialty and when?

Drug Allergies? None Yes - list:

Any Chronic Illnesses? None Yes - list:

Is child taking any regular medications? None Yes - list each with dose and frequency:

Are there any medical issues we should be aware of? None Yes - list:

Family Medical History (Child's Father, Mother, Siblings, Grandparents - Circle all that apply):

Alcohol Abuse Anemia Asthma Birth Defects Cancer Cystic Fibrosis Diabetes Heart Disease
High Blood Pressure High Cholesterol Kidney Disease Migraines Psychiatric Problems
Seizure disorder Stroke Tuberculosis Other _____

*Parent / Legal Guardian Sign*_____ *Date*_____