SOUTH BEACH MEDICAL ASSOCIATES
Child Medical History

Patient Name:
DOB:
Date:

Allergies: (Include name of medication or food, reaction, and age of onset)

_____

_____

Current Problems:

_____

_____

History:

Birth History:

Birth Length: _____ Birth Weight: _____ Birth Head Circumference: _____
Discharge Weight:_____ Gestational Age at Birth (weeks):_____ Delivery Method: Vaginal C-section
If C-section, why? _____

APGAR scores: 1 min ____ 5 min _____ 10 min _____ Infant Feeding: Breast Bottle Both
Formula name: _____

Hearing Screening: Pass Fail Re-testing Heart disease screening: Pass Fail

Medical History: (Check any that have been diagnosed and comment below)

__Hospitalizations?
__Asthma
__Allergic Rhinitis
__Eczema
__Wheezing
__Food Allergies
__Murmur
__Congenital Heart Disease
__Prematurity
__GE Reflux
__Constipation
__Anemia
__Recurrent Ear infections
__Recurrent Strep
__Urinary Tract Infection (UTI)
__Vesicoureteral Reflux (VUR)
__Diabetes
__Vision problems
__Developmental Delay
__Seizures
__ADD/ADHD
__Mental Illness
__Substance Abuse

Other Medical History: _____

_____

Surgical History: _____**No Surgeries**
(Check any past surgeries and complete age/date and surgeon if known)

Procedure	Date or Age	Surgeon
Adenoidectomy		
Appendectomy		
Ear Tubes		
Fundoplication		
Gastrostomy Tube Placement		
Heart Surgery		
Hernia Repair		
Orthopedic Surgery		
Tonsillectomy		
Urological Surgery		
VP Shunt		

Other Surgical History: _____

_____

Patient Name:
DOB:
Date:

Family History: (Check any known problems in the family – please complete *at least* for parents and siblings)

Relationship to CHILD		Name	Alive?	No Known Problems	ADHD/ADD	Allergies	Anemia	Asthma	Cancer	Diabetes	Eye Disease	GI Problems	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Migraines	Seizures	Substance Abuse	Thyroid Disease	Other
Biological Mother			Y N																			
Biological Father			Y N																			
Siblings	Brother Sister		Y N																			
	Brother Sister		Y N																			
	Brother Sister		Y N																			
	Brother Sister		Y N																			
	Brother Sister		Y N																			
Grandparents	MGM		Y N																			
	MGF		Y N																			
	PGM		Y N																			
	PGF		Y N																			

Comments (including *Other* responses): _____

Relationships: P=Paternal (father's side of family), M=Maternal (mother's side of family), GM=Grandmother, GF=Grandfather

For example: MGM = Maternal Grandmother

Additional Family History (if needed)

Relationship to CHILD	Name	Alive?	No Known Problems	ADHD/ADD	Allergies	Anemia	Asthma	Cancer	Diabetes	Eye Disease	GI Problems	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Migraines	Seizures	Substance Abuse	Thyroid Disease	Other
		Y N																			
		Y N																			
		Y N																			
		Y N																			
		Y N																			
		Y N																			

Home Environment:

Number of People at Home: _____
Lives with primary guardians: Yes No
Foster Care: Yes No
Primary Care Givers (circle): Parents Daycare Relatives Others: _____
Daycare (hours/day): _____
Time at Relatives (hours/day): _____
Pets: Yes No

Parent's Status: Married Divorced Single Other _____

Parent #1 Occupation: _____ Parent #2 Occupation: _____