

Associates in Pediatric & Adolescent Medicine

PATIENT HISTORY

Name: _____ Date of Birth: _____
Referred by: _____ Previous MD: _____

Birth History

Birth Weight: _____ lbs. _____ oz. (Circle one) Vaginal Delivery or C/S or Adopted
Illness During Pregnancy: _____
Problems after delivery: _____ Nutr: Breast: _____ Formula: _____

Past Medical History

Hospitalizations	Y	N	Surgeries	Y	N
Serious Accidents	Y	N	Fractures	Y	N
Hay Fever/Sinus/Allergy	Y	N	Asthma/ Wheezing	Y	N
Seizures	Y	N	Chicken Pox	Y	N
Vision Problems	Y	N	Hearing Problems	Y	N
Heart Murmur	Y	N	Recurrent Ear Infections	Y	N
Learning Problems	Y	N	Depression	Y	N

Please explain all yes answers and other conditions: _____

Allergy to medicines: _____ Dietary Restrictions: _____
Current Medicines: _____

Immunizations Up to Date? _____ Grade (School) _____

Family History

Allergic Rhinitis/Hay Fever/"Sinus"	Y	N	Asthma	Y	N
Atherosclerosis (Cholesterol > 240)	Y	N	Hypertension	Y	N
Diabetes	Y	N	Lazy Eye (Strabismus)	Y	N
Hearing Problems (congenital)	Y	N	Seizures	Y	N
Kidney Disease	Y	N	Bleeding Problems	Y	N
Migraine Headaches	Y	N	Mental Illness	Y	N
Depression	Y	N	Anxiety	Y	N
Learning Problems (ADHD/Processing/Dyslexia)				Y	N
Heart Attacks (MI) / Strokes (CVA)/Heart Problems under 55 yrs.				Y	N

Please explain all yes answers: _____

Social History

Pets? Y N if so, what kind? _____ Smokers in home: Y N

Mother's Name: _____ Age: _____

Occupation (Business): _____

Father's Name: _____ Age: _____

Occupation (Business): _____

Sibling's Name (DOB): _____ M or F

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