PEDIATRIC MEDICAL HISTORY FORM

Rocky Mountain Pediatrics, PC
2020 Wadsworth Blvd., Ste. 16
Lakewood, CO 80214
(303)233-8701

Name: ____
Date of birth: _________________**Age:**____________

Date:__________________________________ Male Female

Birth History

Birth Weight ________________Was the delivery Vaginal Cesarean If cesarean, why?________________
Birth Length ___________________ Birth Head Circumference ______________________
Was the baby born at term Early Late If early, how many weeks gestation? ________________________
Did your baby have any problems right after birth? No Yes Explain________________________________
Did mother have any illness or problem with her pregnancy? No Yes explain__________________________
During pregnancy, did mother: Smoke: NO Yes Drink alcohol: NO Yes
Use drugs or medication: NO Yes What_____________________________When____________________
Was your baby's initial feeding Breast Bottle
Did your baby go home with mother from the hospital? No Yes explain_____________________________

General

Do you consider your child to be in good health? No Yes Explain_________________________________
Does your child have any serious illness or medical condition? No Yes Explain_________________________
Has your child had serious injuries or accidents? No Yes Explain__________________________________
Has your child had any surgeries? No Yes Explain____
Has your child ever been hospitalized? □No □Yes Explain______________________________________
Is your child **allergic** to any medications or drugs? No Yes Explain__________________________________

Development

Are you concerned about your child's physical development? No Yes Explain__________________________
Are you concerned about your child's mental or emotional development? No Yes Explain________________
Has he/she failed or repeated a grade in school? No Yes
Is he/she in special or resource classes? No Yes Explain____

Family History

Have any family members had the following:

Asthma No Yes Who_________________Comments_______________________
Heart Disease(before age 50) No Yes Who_________________Comments_______________________
High Blood Pressure(before age 50) No Yes Who_________________Comments_______________________
High Cholesterol No Yes Who_________________Comments_______________________
Stroke No Yes
Who_________________Comments_______________________
Migraines No Yes Who_________________Comments_______________________
Obesity No Yes Who_________________Comments_______________________
Anemia or Bleeding Disorder No Yes Who_________________Comments_______________________
Liver Disease No Yes Who_________________Comments_______________________
Stomach/Intestinal Problems No Yes Who_________________Comments_______________________
Genital/Urinary Problems □No □Yes Who_________________Comments_______________________

Kidney Disease No Yes Who________________Comments______________________
Lung Problems No Yes Who________________Comments______________________
Thyroid Disorders No Yes Who________________Comments______________________
Diabetes (before age 50) No Yes
Who________________Comments______________________
Epilepsy or convulsions No Yes Who________________Comments______________________
Drug or Alcohol Abuse No Yes Who________________Comments______________________
Mental Illness or Depression No Yes Who________________Comments______________________
Tuberculosis No Yes Who________________Comments______________________
Immune problems, HIV or AIDS No Yes Who________________Comments______________________
Cancer No Yes Who________________Type:______________________
Genetic Disorders No Yes Who________________Comments______________________
Additional family history:____

Past History/Surgeries

Does your child have, or has he/she ever had:

Chickenpox No Yes Comments______________________
Frequent ear infections No Yes Comments______________________
Problems with ears or hearing No Yes Comments______________________
Problems with eyes or vision No Yes Comments______________________
Asthma, bronchitis, bronchiolitis, pneumonia No Yes Comments______________________
Heart problem or heart murmur No Yes Comments______________________
Anemia or bleeding problem No Yes Comments______________________
Blood transfusion No Yes Comments______________________
Bladder or kidney infection No Yes Comments______________________
Bed-wetting (after age 5) No Yes Comments______________________
(For girls) Has started menstruation No Yes Comments______________________
Age of 1st menses ______________________________
(For girls) Problems with her period No Yes Comments______________________
Any chronic or recurrent skin problem No Yes Comments______________________
Convulsions or other neurologic problems No Yes Comments______________________
Diabetes No Yes Comments______________________
Thyroid or endocrine problem No Yes Comments______________________
Use of alcohol or drugs No Yes Comments______________________
Any other significant problem or surgery
____

Social History

Who lives in the household? ______________________________
____
____
____

Smoke Exposure No Yes Comments______________________

Any other concerns? No Yes Comments______________________