PREMIUM CARE PEDIATRICS, P.C.
Patient Medical History Form

Date: Child's Name: Mother's Name: Occupation:

DOB: Nickname: Gender M F Cell: Age:

Address: Email:

Phone: Father's Name: Occupation:

Previous Physician/Office: Cell: Age:

Request for Records Transfer Complete Y N Date of Last Physical: Email:

Birth, Current and Past History

Birth weight: Preg # Mom's age:

Was the baby born on time? Y N

If early, how many weeks?

Did mother have any illness or problems with her pregnancy? Y N

Explain:

Is your child adopted? Y N At what age?

During pregnancy, did mother: Smoke: Y N

Drink alcohol: Y N Use drugs or medications: Y N

Explain:

Was the delivery: Vaginal? Cesarean?

If Cesarean, why?:

Did your baby have any problems right after birth? Y N

Explain:

Was initial feeding: Breast Milk? Formula?

Did your baby go home with mother from the hospital? Y N

Explain, if no:

Is your child currently on any medication?	Y	N	Explain:	
Does your child have any serious or chronic illnesses?	Y	N	Explain:	
Has your child had serious injuries or accidents?	Y	N	Explain:	
Has your child had any surgery?	Y	N	Explain:	
Has your child ever been hospitalized?	Y	N	Explain:	
Is your child allergic to any medicine or foods?	Y	N	Explain:	
Has your child had any reactions to immunizations?	Y	N	Explain:	
Does your child have, or ever had?				
Asthma, recurrent cough, bronchitis, or pneumonia	Y	N	Explain:	
Seasonal allergies or eczema	Y	N	Explain:	
Frequent ear infections or sore throats	Y	N	Explain:	
Problems with ears or hearing	Y	N	Explain:	
Problems with eyes or vision	Y	N	Explain:	Date last eye exam:
Problems with teeth	Y	N	Explain:	Date last dental exam:
Frequent headaches or other neurologic problems	Y	N	Explain:	
Frequent abdominal pain	Y	N	Explain:	
Constipation	Y	N	Explain:	
Bladder/kidney infection or bed-wetting after 5 years old	Y	N	Explain:	
Heart problem or heart murmur	Y	N	Explain:	
Anemia or bleeding problem	Y	N	Explain:	
Thyroid or other endocrine problem	Y	N	Explain:	
Diabetes	Y	N	Explain:	
ADHD	Y	N	Explain:	
Mental health issues (anxiety, depression)	Y	N	Explain:	
Use of alcohol or drugs	Y	N	Explain:	

Child's Name: DOB:

Birth, Current and Past History Continued

Any other medical or mental health issues/problems:

Does our child see any specialists? Y N If yes who?

For what reason or diagnosis?

Has your child ever received Occupational Therapy, Y N Explain:

Physical Therapy, Speech Therapy? Y N Explain:

What grade is your child in? Name of School:

Is your child in any special or resource classes in school? Y N Explain:

Do you have any other issues or concerns not listed above?

Household Information

Please List Everyone Living In The Child's Home

Name	**Relationship To Child**	**Age**

Child Care:

Smokers in household? Y N Pets in household? Y N Home Built before 1978? Y N Guns in the home Y N

Are there siblings not listed? If so, please list their names and ages and where they live:

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home?

Family Medical History (Parents, Siblings, Grandparents, Aunts & Uncles)

Have Any Family Members Had Problems With The Following?		
Alcohol/Drug Abuse	Y N Who:	Explain:
Allergies	Y N Who:	Explain:
Anesthesia	Y N Who:	Explain:
Arthritis/bone/joint	Y N Who:	Explain:
Blood Disease	Y N Who:	Explain:
Cancer	Y N Who:	Explain:
Diabetes	Y N Who:	Explain:
Genetics	Y N Who:	Explain:
Gastroenteritis/colitis/reflux	Y N Who:	Explain:
Genitourinary	Y N Who:	Explain:
Heart	Y N Who:	Explain:
Hypertension	Y N Who:	Explain:
High Cholesterol	Y N Who:	Explain:
Neurologic Diagnosis	Y N Who:	Explain:
Psychiatric / Mental health	Y N Who:	Explain:
Ophthalmologic	Y N Who:	Explain:
Respiratory/asthma	Y N Who:	Explain:
Skin	Y N Who:	Explain:
Stroke	Y N Who:	Explain:
Thyroid/endocrine	Y N Who:	Explain:

Additional Family History/Comments:

Preferred Pharmacy

Name: Phone:

Address:

Initial Review (initials/date)