

Pisgah Family Health – Child Medical History

Patient Information

Name: _____ Age: _____

Please list all adults who are permitted to bring the child for care or receive medical information about the child:

Mother step: Name _____ Phone _____ Address _____
 Father step: Name _____ Phone _____ Address _____
 _____ Name _____ Phone _____ Address _____
 _____ Name _____ Phone _____ Address _____

Reason For Visit

Current Symptoms

Pharmacy

Name _____ Location _____ Phone Number _____

Medications Currently Used None

(Include over-the-counter and herbal medications)

Drug Name _____ Dose _____ Frequency _____

Drug Name _____ Dose _____ Frequency _____

Drug Name _____ Dose _____ Frequency _____

Allergies None

(Include foods, insects, and over-the-counter medications)

Drug _____ Reaction _____ Food _____ Reaction _____

Drug _____ Reaction _____ Food _____ Reaction _____

Drug _____ Reaction _____ Other _____ Reaction _____

Do You See Any Other Doctors? No

Dr. _____ Specialty/Group: _____ for _____

Dr. _____ Specialty/Group: _____ for _____

Birth History **Unknown due to adoption**

Birth Weight _____	<u>Pregnancy Problems</u>	<u>Delivery Problems</u>	<u>Newborn Problems</u>
Birth Length _____	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Induced for _____	<input type="checkbox"/> Jaundice
Weeks Gestation _____	<input type="checkbox"/> Group B Strep	<input type="checkbox"/> Vacuum / Forceps	<input type="checkbox"/> Breathing
Type of Delivery _____	<input type="checkbox"/> Tobacco, Drug, Alcohol use	<input type="checkbox"/> Excess Bleeding	<input type="checkbox"/> Infection
APGAR scores _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

Past Medical History **None**

Surgical History **None**

Family History

List all family members who come to Pisgah Family Health

List all blood relatives who have had the following problems:

Blood disorders		Stroke	
Asthma		Heart Disease	
Mental retardation		Diabetes	
Muscular Dystrophy		High Cholesterol	
Epilepsy or Seizures		High Blood Pressure	
Birth Defects		Obesity	
Cystic Fibrosis		Drug or Alcohol problems	
Migraine Headaches		Mental Illness	
Cancer			

Social History - Child

Parents' Marital Status

- Unmarried
 Married
 Divorced
 Separated
 Other _____

Who lives with the child?

- Mother _____
 Father _____
 Step-Mother _____
 Step-Father _____
 Siblings _____

Others _____

Parents' Occupations

Mother _____
 Father _____
 Step-Mother _____
 Step-Father _____

Who cares for the child?

- Mother
 Father
 Daycare
 Grandparents
 Others _____

Who Smokes in the House?

- Nobody
 Mother
 Father
 Others _____

School and Activities:

- Home Schooled
 Days missed last year _____
 Discipline Problems _____
 Grade Level _____
 Grades earned _____
 Special Needs _____
 Sports _____

 Extracurriculars _____

 Hobbies _____

 Employment _____

How Many Hours per day of:

Sleep _____
 School _____
 Daycare _____
 Homework _____
 Television _____
 Video Games _____
 Computer/Internet _____
 Outside Play _____

