REGIONAL PEDIATRIC ASSOCIATES

PATIENT MEDICAL INFORMATION SHEET

Patient Name: ______________________ **DOB:** ______________

PAST MEDICAL HISTORY:

Did the mother have problems/illnesses during pregnancy? ☐ yes ☐ no If yes, please explain

Did the mother use any medications during pregnancy? ☐ yes ☐ no If yes, please explain

Were there any complications with labor and/or delivery? ☐ yes ☐ no If yes, please explain

Did the mother use any alcohol, cigarettes or drugs? ☐ yes ☐ no If yes, please list

Birth weight ______. Were there problems in the newborn period? ☐ yes ☐ no If yes, please list

Has your child had recurrent: ☐ ear infections ☐ bronchitis ☐ pneumonia ☐ kidney infections ☐ seizures

Does your child have other current or recurrent medical problems? ☐ yes ☐ no If yes, please explain

List any medications your child regularly takes: ______________________

Has your child been hospitalized? ☐ yes ☐ no If yes, please explain ______________________

Has your child had any surgery? ☐ yes ☐ no If yes, please explain ______________________

Has your child had allergic reactions to: ☐ Medications ☐ Foods ☐ Stings/Bites ☐ Immunizations
If yes, please explain ______________________

Is your child exposed to smoking? ☐ yes ☐ no

FAMILY HISTORY (List Parents and Children)

Name: ______________________ DOB: __________ Relationship: __________
Name: ______________________ DOB: __________ Relationship: __________
Name: ______________________ DOB: __________ Relationship: __________
Name: ______________________ DOB: __________ Relationship: __________
Name: ______________________ DOB: __________ Relationship: __________

Has Any One in your Child's Family Had:

ILLNESS	RELATIONSHIP	ILLNESS	RELATIONSHIP
Asthma/Allergies ☐ Y ☐ N		Migraines ☐ Y ☐ N	
High Blood Pressure ☐ Y ☐ N		Seizures ☐ Y ☐ N	
Heart Diseases ☐ Y ☐ N		Thyroid Problems ☐ Y ☐ N	
Stroke ☐ Y ☐ N		Kidney Problems ☐ Y ☐ N	
Cancer ☐ Y ☐ N		Eye Diseases ☐ Y ☐ N	
Diabetes ☐ Y ☐ N		*Including Glaucoma*	
Mental Illness ☐ Y ☐ N		Arthritis ☐ Y ☐ N	
Alcohol or Drug Use ☐ Y ☐ N		Anemia/Sickle Cell ☐ Y ☐ N	

Are there any other diseases that run in your child's family? ______________________

Parent/Guardian Signature: ______________________ Date: ______________

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