

Patient History

Child's name: _____ **Date** _____

How did you hear about Mid-City Pediatrics? _____

Family History (please check all that apply for your extended family)

- | | | |
|--|---|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> allergies | <input type="checkbox"/> anemia |
| <input type="checkbox"/> bleeding problems | <input type="checkbox"/> birth defects | <input type="checkbox"/> cancer |
| <input type="checkbox"/> seizures | <input type="checkbox"/> diabetes | <input type="checkbox"/> hearing problems |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> heart problems | <input type="checkbox"/> mental retardation |
| <input type="checkbox"/> headaches | <input type="checkbox"/> kidney problems | <input type="checkbox"/> sickle cell trait/disease |
| <input type="checkbox"/> substance abuse | <input type="checkbox"/> alcoholism | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> high cholesterol | <input type="checkbox"/> menstrual problems | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> depression | <input type="checkbox"/> vision problems | <input type="checkbox"/> domestic violence |
| <input type="checkbox"/> learning disability | <input type="checkbox"/> hyperactivity | |

Please explain any checked items:

Mother's height _____ Father's height _____

Patient's Medical History (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> allergies | <input type="checkbox"/> anemia |
| <input type="checkbox"/> bleeding problems | <input type="checkbox"/> constipation | <input type="checkbox"/> birth defects |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> hearing problems | <input type="checkbox"/> speech problems |
| <input type="checkbox"/> attention deficit/hyperactivity | <input type="checkbox"/> mental retardation | <input type="checkbox"/> headaches |
| <input type="checkbox"/> seizures | <input type="checkbox"/> sickle cell | <input type="checkbox"/> recurrent infections |
| <input type="checkbox"/> kidney problems | <input type="checkbox"/> heart problems | <input type="checkbox"/> bedwetting |
| <input type="checkbox"/> poor appetite | <input type="checkbox"/> learning disability | <input type="checkbox"/> depression |
| <input type="checkbox"/> vision problems | <input type="checkbox"/> fatigue | <input type="checkbox"/> physical disability |
| <input type="checkbox"/> bone fractures | <input type="checkbox"/> jaundice | <input type="checkbox"/> smoke exposure |

Please explain all checked items: _____

Surgery/ hospitalization/ serious injuries: _____

Does your child need any special aids (hearing aid, wheelchair, glasses etc.)? _____

Does your child have any allergies to medications/foods? Has your child had any reactions to immunizations?
