Shoreline Pediatrics P.C.

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Pediatric Patient Medical Information

Patient Name_____ **Sex** __Male __Female

Birth Date_____ **Birth Weight**____lbs ____ozs. **Length**_____inches **Head Circumference** _____cm

Place of Birth ___Muskegon General ___Hackley ___Other _____ **Delivering Dr.**_____

Type of Delivery ___Vaginal ___C-Section Why?_____

Did you have prenatal care? yes or no How long was your baby in the hospital after birth? ____ day(s)

Birth: premature / on time / overdue Who many weeks early or late?____

Problems at Delivery or in Nursery:

___Infection ___Feeding Problems ___Apnea ___Jaundice ___Other What?_____

Pregnancy Problems: __Diabetes ___High Blood Pressure ___Infection? Type_____

___Others What:_____

Maternal Drugs (during Pregnancy)__Smoking ___Packs/day ___Alcohol ___Drinks/Week

___Prescription Drugs What? When?

___Other Drugs? What? When?

Feedings

If older than one year, is child still on a bottle or pacifier? yes/no

Does the child eat a well balanced diet for their age? yes/no

ALLERGIES:_____

MEDICATIONS:_____

Family History

Are mother and father of this child married? yes/no Living together? yes/no

If child does not live with mother and father, please state living conditions, visitation, etc.:

_____

Who is the main caregiver to this child if other than mother? _____

Will he/she be in daycare? yes/no How often? ____hours/pay ____days/week

Is he/she ever exposed to tobacco smoke ? yes/no Where?_____

Who lives at home with this child? (Mother refers to mother of the child, etc)

Relationship:	**Age:**	**Health problems:**
_____	____	_____
_____	____	_____
_____	____	_____

List any parents, brothers or sisters who don't live with this child:

Relationship:	**Age:**	**Health problems:**
_____	____	_____
_____	____	_____

Hospitalization, Surgeries or serious illness

Date	Illness or surgery	Hospital/physician
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE COMPLETE BACK OF FORM

List all specialists this child has seen: (Dr., specialty and why)

Illness	Child	Mother	Father	Brother	Sister	Other relatives
1 Anemia or other blood problems	☐	☐	☐	☐	☐	
2 Bleeding Tendencies	☐	☐	☐	☐	☐	
3 Sickle Cell disease or trait	☐	☐	☐	☐	☐	
4 Asthma	☐	☐	☐	☐	☐	
5 Hay Fever	☐	☐	☐	☐	☐	
6 Eczema or skin problems	☐	☐	☐	☐	☐	
7 Birth Defects	☐	☐	☐	☐	☐	
8 Cancer	☐	☐	☐	☐	☐	
9 Chromosomal Abnormality	☐	☐	☐	☐	☐	
10 Cystic Fibrosis/lung disease	☐	☐	☐	☐	☐	
11 Diabetes	☐	☐	☐	☐	☐	
12 Elevated Cholesterol levels	☐	☐	☐	☐	☐	
13 Epilepsy, seizures	☐	☐	☐	☐	☐	
14 Hearing problems	☐	☐	☐	☐	☐	
15 Hepatitis	☐	☐	☐	☐	☐	
6 Heart Disease or Heart Attacks	☐	☐	☐	☐	☐	
17 High blood pressure	☐	☐	☐	☐	☐	
18 Immune problems	☐	☐	☐	☐	☐	
19 Repeated infections	☐	☐	☐	☐	☐	
20 Metabolic Problems	☐	☐	☐	☐	☐	
21 Kidney infections or disease	☐	☐	☐	☐	☐	
22 Mental Disease or Disorder	☐	☐	☐	☐	☐	
23 Mental Retardation	☐	☐	☐	☐	☐	
24 Muscular Dystrophy	☐	☐	☐	☐	☐	
25 Rheumatoid Arthritis	☐	☐	☐	☐	☐	
26 Sexually transmitted diseases	☐	☐	☐	☐	☐	
27 Thyroid Disease	☐	☐	☐	☐	☐	
28 Tuberculosis	☐	☐	☐	☐	☐	
29 Vision or eye problems	☐	☐	☐	☐	☐	
30 Other significant illnesses	☐	☐	☐	☐	☐	

Additional details on above by number:_____

Has Your Child Had

yes/no Chickenpox
When? (approx.month/year)_____
yes/no Heart Murmur
yes/no RheumaticFever
yes/no Frequent Infections
yes/no Asthma
yes/no Pneumonia
yes/no Urinary Tract Infection
yes/no Seizures

Developmental History	Age
First rolled over (3-4 mo)	_____
Situp (6-7 mo)	_____
Stand alone (9-12mo)	_____
Walked first steps (10-14 mo)	_____
Said first words (9-13 mo)	_____
Potty trained	_____

Do you have any special concerns that you wish to discuss that are not covered by the above?

_____

Signature:_____ Date:_____

Relationship to child if other than mother :_____