Family Medical Center
OF HART COUNTY

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New Patient Pediatric History Form

Name: _____ DOB: _____ Sex: _____

Place of Birth: _____ Delivering Physician: _____

Labor/Delivery Difficulties □ Yes □ No
If yes, explain: _____

How many pregnancy weeks at delivery? _____weeks Birth Weight: _____ lbs. _____ oz.
Was child a twin delivery? □ Yes □ No If yes, was child: □ Twin A □ Twin B

Members in Household:
□ Father □ Mother □ # of Brother(s) _____ □ # of Sister(s) _____ □ # of Grandparent(s) _____
Other Living Arrangements: □ Foster Care □ Adopted

Complications of Newborn Period

(Check and explain answers that apply)

□ Birthmarks
□ Birth Defects
□ Caesarean Section Why: _____
□ Circumcision (male)
□ Feeding Problems
□ Infections Antibiotics: _____
□ Intensive Care Nursery
□ Jaundice Were Bili Lights used? □ Yes □ No
□ Milk Intolerance
□ Respiratory Distress
□ Vomiting

Patient Past Medical History

(Check answers that apply)

□ Asthma
□ Food Intolerance
□ Hepatitis
□ Measles
□ Recurrent Ear Infections
□ Rubella
□ Whooping Cough
□ Chicken Pox
□ Hearing Difficulties
□ Learning Difficulties
□ Mumps
□ Recurrent Pneumonia
□ Vision Difficulties
□ Other _____
□ Seizures Seizure Medication: _____
□ Surgery Type of Surgery: _____ When: _____
□ Hospitalization Why: _____ When: _____
Is the patient on any long term medications? □ Yes □ No
If yes, medication names: _____
What type of water supply does your home have? □ Cistern □ Well □ City

Allergies

□ Allergy Injections Allergist Name: _____
□ Food Allergy
□ Latex Allergy
□ Any Other Known Allergies: _____

Has the patient ever had an allergic reaction to:
□ Medication □ Yes □ No **If yes**: _____
□ Injection □ Yes □ No **If yes**: _____

Tobacco History

Is the patient exposed to tobacco? □ Yes □ No
Type of tobacco exposure: □ Cigarette □ Cigar/Pipe □ Smokeless
Has the patient used tobacco? □ Yes □ No If yes: □ Current □ Past **Last used**: _____
Tobacco type used: □ Cigarette □ Cigar/Pipe □ Smokeless

Immunization History

Vaccine	**Date**	**Vaccine**	**Date**
DPT Vaccine	_____	MMR Vaccine	_____
Hepatitis A Vaccine	_____	Prevnar Vaccine	_____
Hepatitis B Vaccine	_____	Oral Polio/IPV	_____
HIBS Vaccine	_____	Rotavirus Vaccine	_____
TB Skin Test	_____	Adult TD/Boostrix	_____
Chicken Pox Vaccine	_____	Pneumovax Vaccine	_____

Feeding History

Is your child currently on:
□ Formula Name _____ □ Breast Milk □ Whole Milk

How old was your child when they:

Learned to Read _____
Put Two Words Together _____
Rolled Over _____
Sat Up _____
Walked _____

How old was your child when they started eating:

Cereal _____
Fruit _____
Green Vegetables _____
Meat _____
Yellow Vegetables _____

Has your child had any behavior difficulties? If so please explain:
_____
_____
_____

Family History

(Check all answers and family members that apply)

(F=Father; M=Mother; B=Brother; S=Sister; MGF=Maternal Grandfather; MGM=Maternal Grandmother; PGF=Paternal Grandfather; PGM=Paternal Grandmother)

□ Anemia	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Asthma or Hay Fever	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Birth Defects	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Bleeding Diseases	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Color Blindness	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Cystic Fibrosis	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Deafness	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Diabetes	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Eczema	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Epilepsy	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Gallbladder Disease	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Heart Disease	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ High Blood Pressure	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Kidney Disease	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Mental Retardation	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Muscular Dystrophy	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Obesity	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Sickle Cell Anemia	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Stroke before age 60	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Thyroid Disease	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Tuberculosis	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Ulcers	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ PTSD	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Depression	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Schizophrenia	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ OCD	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Bipolar	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM
□ Cancer	□ F	□ M	□ B	□ S	□ MGF	□ MGM	□ PGF	□ PGM

Type of cancer: _____

□ Other Diseases _____

Legal Consent Form for Minors

I, _____, being the legal parent or guardian of, _____, give permission for the providers at Family Medical Center to give necessary treatment and perform necessary procedures in the event I cannot be reached when my child is brought in by anyone of the following person(s):

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

My contact phone number(s) are:

_____ Home

_____ Cell

_____ Work

_____
Parent or Guardian Signature

_____
Date