Medical History Information

Child's full name: _____ Date: _____

Name used: _____ Date of birth: _____ Due date: _____

Multiple Birth: ❑ Y ❑ N Birth weight: _____ Length: _____ Type of delivery: _____

American born: ❑ Y ❑ N City of Birth: _____

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Declined
❑ Native Hawaiian or Pacific Islander ❑ White

Ethnicity: ❑ Declined ❑ Hispanic or Latino ❑ Non Hispanic or Non Latino

Apgar score (if known) _____ Blood type of mother: _____ Blood type of infant: _____

Illness or medication in pregnancy: _____

Illness in newborn period: _____

Has Your Child had any of the following?

❑ Asthma ❑ Ear Infection ❑ Chicken Pox _____ (Year)

❑ Allergies ❑ Pneumonia ❑ Bronchitis ❑ Urinary Tract Infection

❑ Other Illnesses/ Problems: _____

Hospital stays/surgeries: _____

Is your child allergic to any medications or foods? ❑ Y ❑ N

Please list allergies: _____

_____

Are immunizations up to date: ❑ Y ❑ N ❑ Not sure

Who lives in the household with the Child:

❑ Mother ❑ Father ❑ Stepmother ❑ Stepfather

❑ Siblings ❑ Grandparents ❑ Stepsiblings ❑ Boyfriend / Girlfriend of parent

❑ Other: _____

FAMILY HISTORY

Mother's Name: _____ Age: _____ Health: _____

Father's Name: _____ Age: _____ Health: _____

Sibling: _____ Age: _____ Health: _____

Sibling: _____ Age: _____ Health: _____

Sibling: _____ Age: _____ Health: _____

Sibling: _____ Age: _____ Health: _____

Do any family members have the following? (If so, whom?)

Allergies: _____ Asthma: _____ Blood/Bleeding Disorders: _____

Diabetes: _____ Early Heart Disease: _____

Miscarriages: _____ Mental Retardation: _____

Seizures: _____ Tuberculosis: _____

Multiple births: _____

For Office Use Only:
Date: _____
Initials: _____