CHILDREN'S CLINIC OF PENSACOLA, P.A.

MEDICAL HISTORY FORM

Date: _____

Child's Name: _____ **Date of Birth**: _____

Birth History:

Birth Weight: _____ ❒ Full-Term ❒ Premature, # weeks: _____ ❒ Boy ❒ Girl
❒ Vaginal ❒ C/ Section, due to: _____
Hospital Name/State: _____
Pregnancy concerns? ❒ No ❒ Yes (Please explain)
_____

Any medical problems with your newborn after delivery? ❒ No ❒ Yes
Please describe any newborn problems: _____

Specialty Care:
Has your child ever seen a medical specialist? ❒ No ❒ Yes (Please explain):

Past Medical History:
Does your child have a history of any medical conditions? ❒ No ❒ Yes (please circle any that apply)

Genetic: chromosome abnormality other: _____
Neurologic: seizures migraines concussion head trauma other: _____
Respiratory: asthma BPD croup pneumonia seasonal allergies other_____
Cardiac: heart murmur VSD ASD other: _____
Gastrointestinal: constipation acid reflux liver disease pyloric stenosis other: _____
Urology: urinary tract infections urinary reflux kidney disease enuresis other:_____
Muscle/Bone: club foot hypotonia scoliosis other:_____
Dermatology: eczema acne warts molluscum hemangioma other: _____
Infectious: tuberculosis HIV meningitis ear infections strep throat other: _____
Heme/Onc: anemia leukemia cancer other: _____
Behavior/Mood: ADHD anxiety obsessive/compulsive depression other: _____
Development: delay-speech/language delay-motor skills autism other: _____
Learning: special education dyslexia other: _____
Speech: articulation/speech therapy other: _____
Hearing: ear tubes hearing loss other: _____
Vision: lazy eye blurred vision astigmatism cataract other: _____

Additional Details: _____

Hospitalizations: ❒ none
Date: _____ due to: _____
Date: _____ due to: _____

Surgeries: ❒ none
Date: _____ due to: _____
Date: _____ due to: _____

Current Medications: ❒ none
(name) (dose)
_____
_____
_____
_____

Allergies: ❒ none known
(Name and reaction)
Medication: _____
Food: _____
Pets: _____
Seasonal: _____
Indoor: _____
Latex: _____

Family History:

Other Children (names/ages):

_____ _____

_____ _____

Please list any family medical conditions:

Mom: _____
Dad: _____
Sister/Brother: _____
Grandparents: _____
Cousins: _____

Care/Education:

❒ home ❒ day care ❒ pre-school ❒ school-grade _____ ❒ home school ❒ college

Home Environment:
Parents: ❒ married ❒ single/live together ❒ single-parent ❒ divorced
Guns: ❒ no ❒ yes – locked away? _____
Smokers: ❒ no ❒ yes -- ❒ inside ❒ outside
Home Type: ❒ house ❒ apartment
Pets: ❒ no ❒ yes – type? _____

Please describe any other specific concerns you would like to discuss regarding your child?
_____

How did you find out about our practice?
_____