Pisgah Family Health – Child Medical History

Patient Information

Name: ____ Age: ____

Please list all adults who are permitted to bring the child for care or receive medical information about the child:

☐ Mother ☐step: Name ________________________ Phone_________________ Address ___________________________
☐ Father ☐step: Name ________________________ Phone_________________ Address ___________________________
☐ ___________ Name ________________________ Phone_________________ Address ____________________________
☐ ___________ Name ________________________ Phone_________________ Address ____________________________

Reason For Visit

____

Current Symptoms

____

____

Pharmacy

Name______________________________ Location_________________________ Phone Number_______________________

Medications Currently Used ☐ **None**

(Include over-the-counter and herbal medications)

Drug Name ____ Dose _____________ Frequency ____________________
Drug Name ____ Dose _____________ Frequency ____________________
Drug Name ____ Dose _____________ Frequency ____________________

Allergies ☐ **None**

(Include foods, insects, and over-the-counter medications)

Drug __________________ Reaction _________________ Food ____________________ Reaction ______________
Drug __________________ Reaction _________________ Food ____________________ Reaction ______________
Drug __________________ Reaction _________________ Other ____________________ Reaction ______________

Do You See Any Other Doctors? ☐ **No**

Dr. ______________________ Specialty/Group: ___________________________ for ______________________________

Dr. ______________________ Specialty/Group: ___________________________ for ______________________________

Birth History ☐ Unknown due to adoption

Birth Weight ____________
Birth Length ____________
Weeks Gestation _________
Type of Delivery _________
APGAR scores _________

Pregnancy Problems
☐ Diabetes
☐ Group B Strep
☐ Tobacco, Drug, Alcohol use
☐ Other ________________

Delivery Problems
☐ Induced for __________
☐ Vacuum / Forceps
☐ Excess Bleeding
☐ Other _______________

Newborn Problems
☐ Jaundice
☐ Breathing
☐ Infection
☐ Other _______________

Past Medical History ☐ None

____

____

Surgical History ☐ None

____

____

Family History

List all family members who come to Pisgah Family Health

____

List all blood relatives who have had the following problems:

Blood disorders		Stroke	
Asthma		Heart Disease	
Mental retardation		Diabetes	
Muscular Dystrophy		High Cholesterol	
Epilepsy or Seizures		High Blood Pressure	
Birth Defects		Obesity	
Cystic Fibrosis		Drug or Alcohol problems	
Migraine Headaches		Mental Illness	
Cancer			

Social History - Child

Parents' Marital Status
☐ Unmarried
☐ Married
☐ Divorced
☐ Separated
☐ Other _______________

Who lives with the child?
☐ Mother _______________
☐ Father _______________
☐ Step-Mother ___________
☐ Step-Father ___________
☐ Siblings _______________
____
____
____
____
Others __________________
____
____

Parents' Occupations
Mother _________________
Father__________________
Step-Mother _____________
Step-Father______________

Who cares for the child?
☐ Mother
☐ Father
☐ Daycare
☐ Grandparents
Others __________________
____

Who Smokes in the House?
☐ Nobody
☐ Mother
☐ Father
☐ Others _______________
____

School and Activities:
☐ Home Schooled
☐ Days missed last year________
☐ Discipline Problems_________
☐ Grade Level ______________
☐ Grades earned _____________
☐ Special Needs _____________
☐ Sports ___________________
____

☐ Extracurriculars ____________
____

☐ Hobbies __________________
____

☐ Employment_______________
____

How Many Hours per day of:
Sleep ____________
School ___________
Daycare ___________
Homework ___________
Television ___________
Video Games ___________
Computer/Internet ________
Outside Play ____________