redbud pediatrics LLC

Medical History

Patient Name: ____ **DOB:**______________________

Personal Medical History:
During the pregnancy with this child, was there any concern for the infant that was noted by any ultrasound or any obstetrician providing care? ☐ No ☐ Yes_________________________

____

Has your child ever been involved in a serious injury or accident? ☐ No ☐ Yes
If yes, when and why? ____

Has your child ever had surgery? ☐ No ☐ Yes
If yes, when and what procedure? ____
____

Has your child ever stayed overnight in a hospital? ☐ No ☐ Yes
If yes, when and why? ____
____

Please check if your child has had any of the following medical problems:

No	Yes	
☐	☐	Chicken Pox
☐	☐	Frequent Ear or Sinus Infections
☐	☐	Pharyngitis/Tonsillitis
☐	☐	Other Infectious Illnesses
☐	☐	Allergic Rhinitis or other Allergy:
☐	☐	Animal Allergens
☐	☐	Outdoor Allergens
☐	☐	Indoor Allergens
☐	☐	Asthma, Bronchiolitis, Pneumonia, or Croup
☐	☐	Heart Problems or Heart Murmur
☐	☐	Abdominal Pain/ GERD
☐	☐	Constipation requiring doctor visits
☐	☐	Frequent Urinary Tract Infections
☐	☐	Bed-wetting (after 5 yrs of age)
☐	☐	Eye Conditions/Corrective Lenses

No	Yes	
☐	☐	Problems with Ears or Hearing
☐	☐	Chronic or Recurrent Skin Problems (Acne, Eczema, etc)
☐	☐	Anemia or Bleeding Problems
☐	☐	Blood Transfusion
☐	☐	Frequent Headaches
☐	☐	Seizures
☐	☐	Developmental Delays
☐	☐	ADD/ADHD
☐	☐	Mental Health Concerns
☐	☐	Orthopedic Concerns
☐	☐	Diabetes
☐	☐	Thyroid or other Endocrine Problems
☐	☐	If Female and menstrual periods have started, any problems with periods?

Other:______________________________
____

Social History:
Who lives at home? (Including pets) ____
____

Does anyone in your home smoke? ☐ No ☐ Yes

Are there any guns in the home? ☐ No ☐ Yes
If yes, are guns locked and kept separate from ammunition? ☐ No ☐ Yes

PLEASE CONTINUE ON BACK

<u>Family Medical History</u>:

*Please check mark if **your child has a family history** of any of the following**:***

Diagnosis	**Natural Mother**	Natural Father	Sister	Brother	Half-Sister	Half-Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Allergies										
Asthma/ Lung Disease										
Heart Disease/ Condition										
High Blood Pressure										
High Cholesterol										
Diabetes or Other Endocrine Problems										
Cancer, what type?										
Anemia										
Bleeding Disorders										
Epilepsy or Convulsions										
Developmental Disorders										
Neurological Disorders (including ADD/ ADHD)										
Liver Disease										
Other GI Disease/ Disorder										
Kidney Disease										
Bed-wetting (after 10 yr of age)										
Hearing Impairment										
Vision Impairment or Eye Disorder										
Immune Problems, Recurrent Infections, or HIV/AIDS										
Alcohol Abuse										
Drug Abuse										
Mental Health										
Tuberculosis										
Obesity										
Other										

Parent's Signature: ________________________________ **Date:**__________________