Practice Site

MONROE PEDIATRICS

Patient Name: _____

DOB: _____

Date: _____

Allergies: (Include Drug, Reaction, and Age of Onset):

_____

_____

Current Problems:

_____

_____

History:

Birth History:

Birth Length: _____ Birth Weight: _____ Birth Head Circumference: _____

Discharge Weight: _____ Gestational Age at Birth (weeks): _____ Delivery Method: □ Vaginal □ C-Section

Duration of Labor: _____ If C-Section why? _____

APGAR 1m: _____ APGAR 5m: _____ APGAR 10m: _____

Infant Feeding: □ Breast □ Bottle □ Both Formula Name? _____ Newborn Hearing Screening: □Pass □Fail

Other Comments: _____

Medical History: (Check Appropriate Box and Comment in Margins)

ADD/ADHD _____	YES	NO	Allergic Rhinitis _____	YES	NO
Anemia _____	YES	NO	Asthma _____	YES	NO
Congenital Heart Disease _____	YES	NO	Constipation _____	YES	NO
Developmental Delay _____	YES	NO	Diabetes _____	YES	NO
Eczema _____	YES	NO	Food Allergies _____	YES	NO
GE Reflux _____	YES	NO	Mental Illness _____	YES	NO
Murmur _____	YES	NO	Prematurity _____	YES	NO
Recurrent Otitis (ear infections) ___	YES	NO	Recurrent Strep Throat _____	YES	NO
Seizures _____	YES	NO	Substance Abuse _____	YES	NO
UTI _____	YES	NO	Vision Problems _____	YES	NO
Vesicoureteral Reflux _____	YES	NO	Wheezing _____	YES	NO

Other Medical History: _____

_____

Surgical History (Check Appropriate Box)

			Date	Surgeon
Adenoidectomy (adenoids removal) _____	YES	NO		
Appendectomy (appendix removal) _____	YES	NO		
Ear Tubes _____	YES	NO		
Fundoplication _____	YES	NO		
Gastronomy Tube Placement _____	YES	NO		
Heart Surgery _____	YES	NO		
Hernia Repair _____	YES	NO		
Orthopedic Surgery _____	YES	NO		
Tonsillectomy _____	YES	NO		
Urologic Surgery _____	YES	NO		
VP Shunt _____	YES	NO		

Other Surgical History: _____

_____

Practice Site

Patient Name: _____

DOB: _____

Date: _____

Family History: (Check All Boxes That Apply)

Relationship To CHILD		Name	A: Alive	D: Deceased	ADD/ADHD	Allergies	Anemia	Asthma	Cancer	Diabetes	Eye Disease	GI Problems	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Migraines	Seizures	Substance Abuse	Thyroid Disease	Other
Parents	Mother		A	D																		
	Father		A	D																		
Siblings	Sister		A	D																		
	Brother		A	D																		
Aunts/ Uncles	*M Aunt		A	D																		
	*M Uncle		A	D																		
	*P Aunt		A	D																		
	*P Uncle		A	D																		
Grand-parents	*MGM		A	D																		
	*MGF		A	D																		
	*PGM		A	D																		
	*PGF		A	D																		

Comments (including other family medical problems): _____

*M=Maternal, the patient's mother's side of the family *P=Paternal, the patient's father's side of the family

Additional Family History, including other siblings, may be added below:

Relationship to Child	Name																				
		A	D																		
		A	D																		
		A	D																		
		A	D																		
		A	D																		
		A	D																		
		A	D																		

Home Environment:

Number of People at Home: _____

Lives with biological parents: ☐ Yes ☐ No

Foster Care: ☐ Yes ☐ No

Primary Care Givers: ☐ Parents ☐ Daycare ☐ Relatives ☐ Other: _____

Daycare (hours/day): _____

Time at relatives (hours/day): _____

Pets: ☐ Yes ☐ No

Smokers in Home: ☐ Yes ☐ No If Yes, who? _____

Parent's Status:

Parent's marital status: ☐ Married ☐ Divorced ☐ Single ☐ Other: _____

Mother's Occupation: _____ Father's Occupation: _____