



**Chattahoochee Pediatrics Medical History Form**

**Child's Legal Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Family Unit** (list everyone living in household with child)

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Family History:** Are any of the following present in the child's immediate family?

- \_\_\_\_ Asthma \_\_\_\_ Cystic Fibrosis \_\_\_\_ Diabetes \_\_\_\_ Seizures  
\_\_\_\_ Kidney disease \_\_\_\_ High Blood Pressure \_\_\_\_ Learning Disabilities/ADD  
\_\_\_\_ High cholesterol/heart disease at a young age  
\_\_\_\_ Clotting problems/anemia/sickle cell disease/inherited blood disease

**Parents' Marital Status** \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_ Single

**Is this child exposed to passive smoke?** \_\_\_\_ Yes \_\_\_\_ No

For older children, does the child use tobacco, alcohol or recreational drugs? \_\_\_\_ Y \_\_\_\_ N

**Family dentist** \_\_\_\_\_

**Family eye care** \_\_\_\_\_

**Is child in day-care?** \_\_\_\_ Y \_\_\_\_ N If yes, location: \_\_\_\_\_

Is child's care shared by any other household? \_\_\_\_ Y/N

**Patient Medical History:**

Has your child been hospitalized and for what reason? \_\_\_\_\_

List any surgeries \_\_\_\_\_

Birth weight \_\_\_\_\_ Did he/she go home with mom? \_\_\_\_\_

Complications during pregnancy \_\_\_\_\_

Complications at Birth \_\_\_\_\_

How long was he/she breastfed? \_\_\_\_\_

Any problems with early feeding? \_\_\_\_\_

**Chronic Illnesses:** (Asthma, Diabetes, etc.) \_\_\_\_\_

**Allergies:** to food or medications? \_\_\_\_\_

**Medications:** List all the medications your child takes on a regular basis including the dose and frequency taken. Please also include any dietary supplements, herbs and vitamins that your child takes.

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____