

**Premier Community HealthCare Group, Inc.
PEDIATRIC MEDICAL HISTORY**

PATIENT _____ MR # _____ DOB _____

DATE 1ST SEEN _____ SEX _____ RACE _____ REFERRED BY: _____

NEWBORN HISTORY:		
Hospital: _____	Birth Weight: _____	Type of Delivery: _____
<u>Problems during pregnancy:</u> _____	<u>Problems at birth:</u> _____	<u>Problems on discharge:</u> _____

PAST MEDICAL HISTORY

ALLERGIES: _____

PRIOR HOSPITALIZATIONS? Y N

DATE	HOSPITAL	REASON/PROBLEM
1.		
2.		
3.		
4.		

SURGERY? Y N

WHY?	WHEN?
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CHRONIC MEDICATION(S)? IF SO, PLEASE LIST: _____

FAMILY HISTORY: Do either of child's parent, or brothers/sisters have any of the following? (✓)

- | | | | |
|---|--|---|-----------------------------------|
| <input type="checkbox"/> asthma | <input type="checkbox"/> bleeding problems | <input type="checkbox"/> drugs or alcohol | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> sickle cell | <input type="checkbox"/> smoking | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> mental illness | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> inherited problems _____ | |

SOCIAL HISTORY: Smokers in home (including inside or outside the house)? Y N

HOUSEHOLD MEMBERS – Who lives in your home?			
Name	Age	Relationship	Any medical problems?

PARENT: Your Occupation? _____ Working Now? Y N MSFW? Y N

Marital Status: (circle one) M S D Sep. If divorced, who has legal custody? _____

Who helps care for your child if you are sick or at work? _____

Reviewed By: _____ **M.D. Date:** _____