Date: _____ Patient Name: _____ revised: 7/2016

Pecan Tree Pediatrics Medical History Form

DOB: _____

Parent/Guardian 1: _____DOB: _____☐Mother ☐Father ☐Guardian ☐Other

☐Biological ☐Step-parent ☐Adoptive

Parent 2/Guardian: _____DOB: _____☐Mother ☐Father ☐Guardian ☐Other

☐Biological ☐Step-parent ☐Adoptive ☐Deceased

Parent 3/Guardian: _____DOB: _____☐Mother ☐Father ☐Guardian ☐Other

☐Biological ☐Step-parent ☐Adoptive ☐Deceased

Parent 4/Guardian: _____ DOB: _____☐Mother ☐Father ☐Guardian ☐Other

☐Biological ☐Step-parent ☐Adoptive ☐Deceased

If guardian or other, please explain relationship and circumstances: _____

_____

PLEASE PROVIDE ALL LEGAL DOCUMENTS PERTAINING TO CUSTODY AND/OR GUARDIANSHIP

Sibling 1: _____ DOB: _____☐Biological ☐half biological ☐step ☐adopted

Sibling 2: _____ DOB: _____☐Biological ☐half biological ☐step ☐adopted

Sibling 3: _____ DOB: _____☐Biological ☐half biological ☐step ☐adopted

Sibling 4: _____ DOB: _____☐Biological ☐half biological ☐step ☐adopted

If there are more family members in the household, please obtain a second page from the front desk.

_____

BIRTH HISTORY: How many weeks was patient in the womb? _____ Birth weight: _____

☐ vaginal ☐ C section ☐ vacuum ☐forceps ☐Group B Strep (GBS) +

List problems during pregnancy (☐none):

During pregnancy, did the biological mother use ☐tobacco ☐alcohol ☐illicit drugs

☐prenatal vitamins ☐ other medications _____

List problems during labor (☐none):

List problems during delivery (☐none):

Did your child go to the NICU or special care nursery? ☐no ☐yes, please give details:

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Past Medical History:
List all medical conditions, medical issues and serious illness:

_____

_____

_____

List all surgeries with dates and location / hospital / surgeon:

_____

_____

_____

_____

List all hospitalizations with dates, reasons, with location / hospital

_____

_____

If more room for Past Medical History is needed, please see the front desk for an additional form.

_____

Allergies / Adverse Reactions: Does your child have an epi pen: ☐yes, why: _____☐no

Medication, Food or Substance	Reaction

List all medications, including over the counter and multivitamins

Medication	Strength	Dose	Frequency	Reason

If more room is needed, please ask for an additional form

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Family History: (Do any **BIOLOGICAL** relatives have the following, please indicate who using D=dad, M=mom, MGM=mom's mom, MGF=mom's dad, PGM=dad's mom, PGF=dad's dad, B=brother, S=sister, MA=mom's sister, MU=mom's brother, PA=dad's sister, PU=dad's brother) Please specify name of sibling.

	Family Members	**Please explain, specify condition**
ADHD	_____	
Alcohol Abuse/Addiction	_____	
Allergies	_____	
Anemia	_____	
Asthma	_____	
Autism	_____	
Bed-wetting	_____	
Birth Defects	_____	
Blood Disorder (other than anemia)	_____	
Bone/Joint Disease	_____	
Cancer	_____	
Dermatologic / Skin Issues	_____	
Cystic Fibrosis	_____	
Drug Abuse	_____	
Ear Disorders / Hearing Impairment	_____	
Endocrinology	_____	
Thyroid Disorder	_____	□hypothyroidism □hyperthyroidism □thyroid cancer
Diabetes	_____	
Eye Disorder / Vision Impairment	_____	
Genetic Disorders	_____	specify:
Gastrointestinal Disorder	_____	
Heart Disease	_____	
High Blood Pressure	_____	
High Cholesterol	_____	
HIV / AIDS	_____	
Kidney Disease	_____	
Lung Disease (other than asthma)	_____	
Migraines	_____	
Mental Retardation / Developmental Disorder	_____	
Muscle or Orthopedic Issues	_____	
Neurologic Issues (other than seizure)	_____	
Psychiatric Issues	_____	
Rheumatologic Issues	_____	
Seizures / Epilepsy	_____	
Tuberculosis	_____	

If there have been deaths in family members prior to age 50, please list family member relationship, age and reason:

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SOCIAL HISTORY:

Household: List all members in the primary household (where this child spends most of their time)

Name	Relationship	Birth date

If your child spends part of their time at another household, please list their names, relationship and ages:

Name	Relationship	Birth date

What is this child's living situation if not with both biological parents?

_____

_____

Are biological parents: ☐ Married ☐Divorced ☐ Together, but not married ☐Not together ☐Not known

If parents are not together: ☐Joint Custody ☐Single Custody (PLEASE PROVIDE LEGAL DOCUMENTS)

☐one or both parents not involved: explain: _____

☐Lives with adoptive parents. If adoptive: is child aware that he or she is adopted? ☐yes ☐no

☐ Lives with foster family

EXPOSURE HISTORY:

Daycare: ☐No ☐Yes Pets: ☐No ☐Yes: List all animals:

Exposure to smokers: ☐No ☐Yes Who?

If guns in home: Are they locked and kept separate from ammunition: ☐yes ☐no ☐We do not own guns

Pecan Tree Pediatrics recommends that guns be locked up and kept separate from ammunition

Pool / Bodies of water: If your home has a pool or body of water nearby, is it / are they surrounded by a 4-sided fence or other precaution to keep your child safe from accidental drowning? ☐yes ☐no

☐ We do not have a pool or body of water near our home

Pecan Tree Pediatrics recommends that bodies of water near the home be surrounded by a 4 sided fence and direct supervision of children around these bodies of water / pool areas

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information may be dangerous to my child's health. It is my responsibility to inform the doctor's office of any changes in my child's medical status. I authorize the healthcare staff to perform the necessary healthcare services my child may need.

Signature of Parent/Guardian: _____ Date: _____