Martha Jefferson Medical Group

Pediatric

COMPREHENSIVE HEALTH HISTORY

Patient Name:	Patient Date of Birth:
Form completed by:	
Relationship to Patient:	Date Completed:

Birth History (if age 10 or older, Skip to Past Medical History)	
Were there complications during the pregnancy?	☐ Yes ☐ No; If yes, please describe:
Was the child born close to the due day?	☐ Yes ☐ No; If not, how many weeks early or late? Please explain:
Birth Weight:	_____lbs _____ oz
Type of Delivery:	☐ Vaginal ☐ C-Section
Were there problems with jaundice (yellow skin)?	☐ Yes ☐ No
Was there infection at birth?	☐ Yes ☐ No
Did the infant leave the hospital with the mother?	☐ Yes ☐ No
Type of feeding:	☐ Breast fed ☐ Bottle fed; If breast fed, please specify length of time _____ If breast fed, are you giving a Vitamin D supplement? ☐ Yes ☐ No
Were there feeding difficulties?	☐ Yes ☐ No
Past Medical History	
Has the child ever been hospitalized?	☐ Yes ☐ No; If yes, please describe:
Has the child ever had surgery?	☐ Yes ☐ No; If yes, what type of operation and age: If yes, did the child have any difficulties with anesthesia? ☐ Yes ☐
Has the child ever had a serious accident, injury or broken bone?	☐ Yes ☐ No; If yes, please describe:

Has the child ever had any of the following problems?		
☐ acid reflux	☐ developmental problems	☐ seizure
☐ allergies	☐ ear infections	☐ skin conditions
☐ asthma	☐ heart murmur	☐ wheezing
☐ chicken pox	☐ other	☐ other

Current Medications/Vitamins/Herbs/Supplements						
Name of Medication	**Dose**	**Frequency**		**Name of Medication**	**Dose**	**Frequency**

Martha Jefferson Medical Group

Patient Name:	Date of Birth:

Allergies		
Allergies to Medications	☐ **Latex**	**Environmental/Seasonal Allergies**
What is your preferred local pharmacy?		

Family History		
☐ No Knowledge of blood relative history ☐ Adopted		
Please note anyone in the child's family with the following condition. If present, please list relationship to child.		
☐ Alcohol/Drug problem	☐ Diabetes	☐ Psychiatric Illnesses
☐ Allergies	☐ Heart Disease/Heart Attack	☐ Seizure
☐ Asthma	☐ High Blood Pressure	☐ Stroke
☐ Blood disorder	☐ High Cholesterol	☐ Other:
☐ Cancer	☐ Overweight	☐ Other:

Social History	
Who lives at home with the child? Name, age, relationship	
Where and with whom does the child spend the day?	
Are there smokers in the house? ☐ Yes ☐ No	Does your home have a swimming pool? ☐ Yes ☐ No
Do you have pets? ☐ Yes ☐ No; If yes, what type?	
If your child is riding a bicycle, does he/she use an approved bicycle helmet to prevent head injury? ☐ Yes ☐ No	
Is there anything about your medical or personal history that you would like your health care provider to know?	

Reviewed by: _____ **Date:** _____

Revised 12.12 - cw