West Shore Family Practice, P.C.

PEDIATRIC MEDICAL HISTORY

DATE________________
NAME________________
AGE________________

The following information is very important to your child's health. Please take time to fully and completely fill out this important information. We are counting on you.

PREGNANCY: Mother's age during pregnancy:________

During pregnancy: Did Mother smoke?______________; How much?______________

Use alcohol?___________; How much?______________

Medicine/Drugs/X-rays, etc. during pregnancy?________________________________

Problems during pregnancy:

Diabetes, High Blood Pressure/Pre-eclampsia (Toxemia),
Infection, Poor fetal growth, Other:________________________________

BIRTH HISTORY: Birth date________Due Date________Vaginal birth or C-section?

APGAR Scores (if known): 1 min.______ 5 min.______

Birth weight:__________ Length:________ Head circumference:__________

Infant blood type:________

Problems with delivery: Seizures Infection Jaundice Breathing problem
Feeding problem Other________________________

GENERAL HISTORY:

Diet:____

Development (speech, physical skills, social, etc.):

☐No problems

☐Problems (explain): ________________________________

Diseases:____

Operations:____

Hospitalizations:____

Allergies: Medicine:______________Food:______________Other:______________

Medications: Vitamins:______________Other:________________________

FAMILY MEDICAL HISTORY: (Please list: Name, Date of birth and any medical problems - especially diabetes, high blood pressure, heart problems, high cholesterol, asthma, allergies, eczema, tuberculosis, cancer, seizures, bleeding problems).

Biological mother:____

Biological father:____

Siblings:____

____

Grandparents:____

____

Who lives in patient's household(s)?____

The above is true and correct to the best of my belief.

Signature of parent or guardian______________________ Relationship to patient________________