COOKEVILLE PEDIATRIC ASSOCIATES, P.C.
PAST MEDICAL HISTORY FORM

PHYSICIAN CHILD WILL SEE:______________________ DATE: ___/___/___

PATIENT:______________________ RESPONSIBLE PARTY__________________
CHILD'S DOB: ____/____/____

CHILD'S BIRTH HISTORY (IF KNOWN):
Type of delivery (check one) Vaginal ____ C-Section ____
Premature birth? Yes ____ No ____
How many weeks at delivery ______ Birth weight ______ (pounds)
Did the mother have any complications during pregnancy? Yes ____ No ____
Did the mother have any complications during or around the birth? Yes ____ No ____

CHILD'S PAST MEDICAL HISTORY:
Any significant past medical history Yes _____ No _____
Previous hospitalizations? Yes _____ No _____
If yes, explain: ____

Attention Deficit Disorder	Yes ____	No ____	Fracture	Yes ____	No ____
Allergies	Yes ____	No ____	Acid Reflux	Yes ____	No ____
Anemia	Yes ____	No ____	Headache	Yes ____	No ____
Asthma	Yes ____	No ____	Psychiatric Disorders	Yes ____	No ____
Blood disorders	Yes ____	No ____	Migraine	Yes ____	No ____
Bronchiolitis	Yes ____	No ____	Ear infections	Yes ____	No ____
Chickenpox	Yes ____	No ____	Pneumonia	Yes ____	No ____
Chronic illness	Yes ____	No ____	Recurrent colds	Yes ____	No ____
Heart defect	Yes ____	No ____	Sinus infections	Yes ____	No ____
Concussion	Yes ____	No ____	Seizure disorder	Yes ____	No ____
Delayed Developmental Milestones	Yes ____	No ____	Thyroid disorder	Yes ____	No ____
Diabetes Mellitus	Yes ____	No ____	Tonsillitis	Yes ____	No ____
Eczema/Rash	Yes ____	No ____	Trauma	Yes ____	No ____

CHILD'S SURGERY HISTORY:
Significant surgeries Yes ____ if yes, what surgeries:________________________________
No ____

Appendix removal	Yes ____	No ____
Hernia repair	Yes ____	No ____
Tonsils removed	Yes ____	No ____
Ear tubes	Yes ____	No ____

FAMILY HISTORY:

Alcoholism	Yes ____	No ____	High blood pressure	Yes ____	No ____
Asthma	Yes ____	No ____	Juvenile Rheumatoid Arthritis	Yes ____	No ____
Birth defects	Yes ____	No ____	Kidney disease	Yes ____	No ____
Cancer	Yes ____	No ____	Mental illness	Yes ____	No ____
Crohn's Disease	Yes ____	No ____	Mental retardation	Yes ____	No ____
Diabetes	Yes ____	No ____	Migraine	Yes ____	No ____
Drug use	Yes ____	No ____	Stroke	Yes ____	No ____
Epilepsy	Yes ____	No ____	Systemic Lupus	Yes ____	No ____
Heart disease	Yes ____	No ____	Tuberculosis	Yes ____	No ____
High cholesterol	Yes ____	No ____			

CHILD'S SOCIAL HISTORY:

Exposure to cigarette smoke at home	Yes ____	No ____
Living with parents	Yes ____	No ____
Recent contact with pets/animals	Yes ____	No ____
Child enrolled in day-care	Yes ____	No ____
Living in a foster home	Yes ____	No ____
Tobacco use	Yes ____	No ____
Alcohol	Yes ____	No ____
Drug use	Yes ____	No ____

OTHER:

Is there any additional information we may need to know? ____

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