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ATAWBA PEDIATRIC
ASSOCIATES, P.A.

Unifour Medical Commons
240 18th Street Circle, S.E.
Hickory, North Carolina 28602

Appointment: 8am-5pm 828-322-2550
Night: 5pm-8am 828-322-2550

_____
NAME OF CHILD

MEDICAL HISTORY

_____
DATE OF BIRTH

I. BIRTH

A. Length of pregnancy _____

B. Mother during pregnancy

1. Age _____
2. Prenatal care: yes____ no_____Where?_____
3. Blood type (if known): O____ A____ B_____ AB____ Rh: pos. ____ neg. _____
4. Illnesses (circle and give months that occurred)

a. severe vomiting _____ b. swelling _____
c. increased blood pressure _____ d. vaginal bleeding _____
e. viruses (flu, colds, etc.) _____ f. rashes _____
g. kidney infections _____ h. hospitalizations _____
i. depression _____ j. other _____

5. Total weight gain _____ pounds
6. Drugs taken during pregnancy _____

II. C. Labor

1. Spontaneous _____ Induced _____
2. Water broke how long before delivery? _____ days _____ hours
3. Fever during labor or week before? yes _____ no_____
4. Length of labor: _____hours
5. Known distress of baby during labor? yes _____ no_____

D. Delivery

1. Type: Vaginal_____ C-section _____
2. Presentation: Vertex (Head first)_____ Breech (buttocks first) _____
3. Condition at birth _____
4. Type anesthesia: Gas_____ Spinal_____ Local _____ None_____
5. Birthplace: Hospital _____ City _____ State_____

E. Newborn

1. Birth weight _____
2. Blood type (if known): O _____A _____B _____AB _____ (i.e. Rh: pos. _____ neg. _____)
3. Problems in hospital nursery (respiratory difficulties, jaundice, blueness, convulsions, bleeding, feeding difficulties, deformities, others) Yes_____ No _____
   If yes, explain_____
   _____
4. Went home on day number _____

F. Mother's Pregnancy History

1. Total number pregnancies _____
2. Number full term births _____
3. Number weighing less than 5½ pounds _____
4. Stillbirths/miscarriages _____
5. Living children _____
6. This child was pregnancy number _____
7. Difficulties with other pregnancies, labor, delivery, or newborn infants? _____
   If yes, explain _____
   _____

II. FEEDING

A. Breast _____ Formula _____ type _____

1. Weaned from breast at what age _____
2. Taken off formula at what age _____

B. Supplemental vitamins yes _____ no _____ how long? _____

C. Supplemental iron yes _____ no _____ how long? _____

D. Any feeding problem during first year of life? _____ Explain _____

_____

III. GROWTH: Separate form - please provide us with any previous height, weight, or head circumference measurements at your disposal.

IV. DEVELOPMENT: Age child first performed the following:

A. Rolled over _____
B. Sat without support _____
C. Stood unassisted _____
D. Acquired first tooth _____
E. Walked alone (more than 4 steps) _____
F. Said first word (other than mama, dada) _____
G. Put two words together (other than bye-bye) _____
H. Bladder control most of time _____ daytime _____ nights
I. Bowel control most of time _____

V. ALLERGIES

List: A. to what substances allergic (e.g.) drugs, plants, chemicals, animals, dust, foods, unknown, others) and
B. what type reaction experienced (e.g. asthma, hayfever, eczema, hives, rash, etc.)

A. Allergic to:

_____
_____
_____

B. Type reaction:

_____
_____
_____

VI. ILLNESSES

A. Circle previous illnesses. Give approximate age and severity or complications.

1. Asthma or wheezing _____
2. Pneumonia _____
3. Rheumatic Fever _____
4. Chickenpox _____
5. Mumps _____
6. Kidney or bladder infections _____
7. Seizures _____
8. Other _____
9. Other _____
10. Other _____

B. List any illnesses or conditions recurring or persisting for months or years (for example; repeated ear infections, allergies, seizures)

_____
_____
_____

C. Hospitalizations (other than birth, injuries, or surgery)

Diagnosis	Age	Where	Treatment and Outcome

VII. INJURIES

Type	Age	Where Treated	Long-Term Effects

VIII. SURGERY

Type	Age	Where	Complications

IX. ENVIRONMENT

A. Water source: city _____ well _____ other _____

B. Pets (list) _____ C. Farm animals (list) _____

D. Foreign travel (places and dates) _____

E. Persons living in patient's home other than parents/brothers/sisters

1. _____ 3. _____

2. _____ 4. _____

F. Any exposure to chemicals, poisons, fumes? List _____

X. EDUCATION

A. Attended nursery school: yes _____ no _____ where? _____ how long? _____

B. Attended kindergarten: yes _____ no _____ where? _____

C. Age entered first grade: _____ years _____ months

D. Performance in school

1. Overall achievement: below average _____ average _____ above average _____

2. Subjects of special difficulty _____ 3. Grades repeated _____

E. Behavior _____

XI. FAMILY HISTORY

Member	Name	Year of Birth	Health (if deceased, give cause)
Child's Father			
Child's Mother			
Brothers/Sisters of child			
1.			
2.			
3.			
4.			
5.			
6.			

Is there any family history of the following (include grandparents, aunts, uncles, 1st cousins);

1. Asthma (wheezing)
2. Serious allergies
3. Diabetes ("sugar")
4. Convulsions (seizures)
5. Mental retardation
6. Blood disorders
7. Bleeding tendencies
8. Thyroid disease
9. Liver disease
10. Kidney disease
11. Rheumatic fever
12. Childhood heart disease
13. Birth defects
14. Death in first year of life
15. Tuberculosis
16. Cancer
17. Obesity (overweight)
18. High blood pressure
19. Heart attacks before age 50
20. Strokes before age 60
21. Any other condition occuring in 2 or more family members

If yes, list disease or condition below; give relationship of family member to child and specific diagnosis and circumstances (if known).

_____

_____

_____

_____

_____

_____

_____

_____

XII. IMMUNIZATIONS: Separate form - Please provide us with any records of past immunizations from health clinics, school, or other physicians.

XIII. SOCIAL

A. Interpersonal Relationships - Does child have any difficulty in relationships with teachers, other family members, classmates? _____ If so, explain _____

B. Habits - Does child have any habits which have been a problem (thumb sucking, head banging, dirt eating, temper tantrums, nail biting, etc)? _____

C. Sleep - Does child have any sleep difficulties (nightmares, frequent awakening, etc.)? _____

XIV. List any other significant information from the past or present medical history, social situation, or experiences of the patient and his family which might have an effect on his physical or emotional health.
Please explain _____

XV. Additional explanation, clarification, or changes in this form. (Give item number and explain)

Item #	

Form Initially Completed: Date _____ By _____ Relationship _____

Revised _____

Revised _____

Revised _____

Revised _____

Revised _____