BRYN MAWR PEDIATRICS

Patient Name: _____ Date of Birth _____

HOUSEHOLD- please list all those living in the child's home

Name	Age	Relationship to Child	Medical Concerns

BIRTH HISTORY

Place of birth _____ Date of adoption (if applicable) _____
Birth weight _____lbs. _____oz. Discharge weight _____lbs. _____oz. Length _____
Was initial feeding □ Breast □ Bottle Weeks gestation at birth _____ Type of delivery □ Vaginal □ Cesarean
Were there any problems with labor or delivery? □Yes □ No
If yes explain: _____
During the pregnancy with this child, did the mother: (check all that apply)
□ Smoke? □ Drink Alcohol? □ Use Drugs or Medications?
□ Have any illness? Describe: _____

PATIENT'S PAST MEDICAL HISTORY (if applicable) check all that apply

□ Allergies Explain _____
□ Anemia Explain _____
□ Asthma Explain _____
□ Behavior problems Explain _____
□ Bladder/Kidney infections Explain _____
□ Bed wetting Explain _____
□ Broken bones Explain _____
□ Chicken Pox When _____
□ Chronic Cough Explain _____
□ Constipation Explain _____
□ Croup Explain _____
□ Dental Problems Explain _____
□ Depression Explain _____
□ Diabetes Explain _____
□ Ear Infections Explain _____
□ Eczema Explain _____
□ Frequent Abdominal Pain Explain _____
□ Frequent Diarrhea Explain _____
□ Frequent Headaches Explain _____
□ Frequent Nose Bleeds Explain _____
□ Frequent Vomiting Explain _____
□ Head Injuries Explain _____
□ Hearing Problems Explain _____
□ Heart Murmur Explain _____
□ Hospitalization/Surgery Explain_____
□ Menstrual Period (for girls) When _____ List any problems _____
□ Pneumonia Explain _____
□ Seizures Explain _____
□ Scoliosis Explain _____
□ Skin Problems Explain _____
□ Thyroid or other endocrine problems Explain _____
□ Urinary Tract Infections Explain _____

PATIENT'S PAST MEDICAL HISTORY cont.

□ Vision Problems □ Wears glasses □ Contacts Explain _____

□ Other Explain _____

MEDICATIONS

Please list current medications, vitamins, and supplements, even those used intermittently: _____

_____

IMMUNIZATIONS: Please bring your child's immunization records prior to your appointment

Have you ever refused vaccines for your child? □ Yes □ No

If yes, why? _____

FAMILY HISTORY- Have any family members had the following □ Unknown

		RELATIONSHIP TO PATIENT
Alcoholism	□Yes □ No	_____
Allergies	□ Yes □ No	_____
Anemia	□ Yes □ No	_____
Asthma	□ Yes □ No	_____
Autism	□ Yes □ No	_____
Birth Defects	□ Yes □ No	_____
Blood Disorders	□ Yes □ No	_____
Cancer: Please Specify Type: _____	□ Yes □ No	_____
Depression	□ Yes □ No	_____
Diabetes	□ Yes □ No	_____
Drug Abuse	□ Yes □ No	_____
Eczema/Skin conditions	□ Yes □ No	_____
Genetic Disorders	□ Yes □ No	_____
Heart Attack	□ Yes □ No	_____
Heart Disease	□ Yes □ No	_____
High Cholesterol	□ Yes □ No	_____
High Blood Pressure	□ Yes □ No	_____
Immune Disorder	□ Yes □ No	_____
Inflammatory Bowel Disease	□ Yes □ No	_____
Kidney Disease	□ Yes □ No	_____
Mental Retardation	□ Yes □ No	_____
Psychiatric/Mental illness	□ Yes □ No	_____
Scoliosis	□ Yes □ No	_____
Seizure Disorder	□ Yes □ No	_____
Sickle Cell Disease	□ Yes □ No	_____
Thyroid Disorders	□ Yes □ No	_____
Tobacco Use	□ Yes □ No	_____
Tuberculosis	□ Yes □ No	_____
Unexplained or early deaths	□ Yes □ No	_____
Other _____		_____