

Child and Family Medical History

DATE:	AGE:	Reason for visit (well check):																		
Gestation History <p>1. Gravida: _____ Para: _____ Abortions: _____ 2. Prenatal care Yes or No? Number of visits _____ 3. Length of gestation _____ weeks 4. Maternal age at patient's birth _____ 5. Smoking? Yes or No? packs/day _____ 6. Alcohol? Yes or No? Amnt/Freq _____ 7. Drugs (recreation) Yes or No? Name/Freq _____</p>		<p>8. Maternal medications / drugs used during pregnancy 9. Maternal problems during pregnancy: <input type="checkbox"/> anemia <input type="checkbox"/> hospitalization <input type="checkbox"/> syphilis <input type="checkbox"/> cardiac disease <input type="checkbox"/> hypertension <input type="checkbox"/> U.T.I. <input type="checkbox"/> diabetes <input type="checkbox"/> Rh negative <input type="checkbox"/> vaginal bleeding <input type="checkbox"/> gonorrhea <input type="checkbox"/> rubella <input type="checkbox"/> hepatitis <input type="checkbox"/> herpes <input type="checkbox"/> seizures</p>																		
Birth & Nursery Course <p>12. Place of Birth: _____ 13. Problems during labor and delivery? (eg. Induction, postpartum hemorrhage) _____</p> <p>14. Type of delivery: spontaneous, forceps, C-Section. Length of labor: _____ hours 15. Infant's condition at birth: _____ APGAR: 1 min: _____ 5 min: _____ 16. High risk nursery? Yes No Length of time: _____ 17. Birth weight: Length Head Circumference: Small/large for gest age 18. Problems: <input type="checkbox"/> birth defects <input type="checkbox"/> convulsions <input type="checkbox"/> meningitis/sepsis <input type="checkbox"/> blood transfusions <input type="checkbox"/> feeding problems <input type="checkbox"/> oxygen or respirator used <input type="checkbox"/> congenital infections <input type="checkbox"/> jaundice <input type="checkbox"/> other</p>																				
Past Medical History (PMH) Accidents/Illnesses Allergies – "...drug, food, other"		Allergies - drug, food, otherwise Hospitalizations																		
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Current Health Status of Mother Father Siblings																				
Medications taken regularly																				
Developmental History																				
Diet History <i>Diet: see age specific worksheet</i>																				
Social History <i>Who lives at home? Who cares for the baby? Any new changes or stressors at home? Any indoor or outdoor cigarette smoke exposure? Pets? Firearms? Child safety and concern for child abuse?</i>																				