North Dallas
PRIMARY CARE DOCTORS

Your answers on this form will help your provider understand your child's medical history.

CHILD'S NAME:_____ **DATE OF BIRTH:**_____

PERSON COMPLETING FORM/RELATIONSHIP_____

DATE OF FORM COMPLETION_____

MEDICATIONS:

Medication	Dose	How many times a day

MEDICATION ALLERGIES: □ No □ Yes
If yes, to what medication(s) and what was the reaction_____

IMMUNIZATION HISTORY:
To the best of my knowledge, my child is up to date on his/her immunizations □ No □ Yes
If no, why?_____

BIRTH HISTORY:
Please indicate any medical problems during pregnancy _____
Please list any medications taken during the pregnancy_____
Any drug or alcohol use during the pregnancy □No □ Yes _____
Delivered by □ elective C-section □ emergent C-section □ forceps □ vacuum extraction
□ normal vaginal delivery
If not a normal vaginal delivery, why?_____
Number of weeks gestation_____
Birth weight_____ APGAR scores: 1 minute_____ 5 minute_____ Discharge weight_____
Did the baby receive the Hepatitis B vaccine □ No □ Yes If yes, date given _____
Please indicate any medical problems during the newborn period_____
Name of hospital where infant was born_____

PERSONAL MEDICAL HISTORY:
Please check if your child has had any of the following medical problems:

□ ADD/ADHD	□ Chicken pox	□ Headaches	□ Liver disease/Hepatitis
□ Allergies	□ Concussion	□ Hearing problems	□ Recurrent ear infections
□ Anemia	□ Diabetes	□ Heart murmur	□ Seizures
□ Asthma	□ Eczema	□ Congenital heart disease	□ Urinary Tract Infections
□ Bleeding disorder	□ Fracture	□ High blood pressure	□ Vesicoureteral reflux
□ Bronchiolitis	□ Handicaps/Disabilities	□ Kidney disease	□ Vision problems

HOSPITALIZATIONS:
Has your child every stayed overnight in a hospital? □ No □ Yes
If yes, when and why?_____

PHARMACY NAME & ADDRESS:

PHONE NUMBER:

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SURGICAL HISTORY:

Please indicate any surgeries or procedures your child has had. Please include the year the surgery/procedure was performed.

_____

_____

_____

GYN HISTORY:

Age of first period_____years First day of last period_____ Has not had menses yet_____

FAMILY HISTORY:

Please indicate if your child has a family history (**parents, siblings, grandparents, aunts, uncles or cousins <u>to the child</u>**) of any of the following:

Diagnosis	**Family Member**	**Diagnosis**	**Family Member**
□ ADD/ADHD	_____	□ Hearing disability	_____
□ Alcohol/Drug Abuse	_____	□ High cholesterol	_____
□ Allergies	_____	□ High blood pressure	_____
□ Asthma	_____	□ HIV/AIDS	_____
□ Birth defects	_____	□ Learning disability	_____
□ Blood disorders	_____	□ Mental illness	_____
□ Cancer, type	_____	□ Mental retardation	_____
□ Heart disease (heart attack, bypass, stents)	_____	□ Migraines	_____
□ Deafness/Hearing problems	_____	□ Scoliosis	_____
□ Depression	_____	□ Seizure disorder	_____
□ Developmental delay	_____	□ Speech problems	_____
□ Diabetes	_____	□ TB/Lung disease	_____
□ Genetic disorder	_____	□ Stroke	_____
□ Hepatitis/Liver disease	_____	□ Thyroid disease	_____
		□ Other	_____

SOCIAL HISTORY:

Who lives at home?

Name	**Relationship**	**DOB**

Is the child cared for by any one other than the parents? □No □ Yes

If yes, by whom and how frequently?_____

Does anyone in your home smoke? □ No □ Yes

_____