

Medical History

Name of Patient _____ Date of Birth _____

Family Medical History

Please indicate if any family members (parents, siblings, grandparents, uncles, and cousins) have had any of the following conditions:

Diabetes _____	Mental Retardation _____
Cancer _____	Mental Illness _____
Tuberculosis _____	Jaundice _____
Seizures _____	Eczema _____
Heart Disease _____	Hay Fever _____
Kidney Disease _____	Frequent Sinusitis _____
Lung Disease _____	Asthma _____
Blood Disease _____	Food Allergies _____
Birth Defects _____	Drug Allergies _____
Inherited Diseases _____	High Blood Pressure _____

Social History

<input type="checkbox"/> Divorce, if so when? _____	<input type="checkbox"/> Separation, if so when? _____	<input type="checkbox"/> Death in family
<input type="checkbox"/> Severe Illness of family member	<input type="checkbox"/> New Addition to Household	<input type="checkbox"/> Recent move
<input type="checkbox"/> Other _____		

Please list all persons living with the patient and their relation to the patient:

Name	Relation	Name	Relation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Pregnancy and Birth

Due Date: _____ Birth weight: _____

Did mother have regular prenatal care: Yes No Unsure

Please describe any complications during this pregnancy: _____

Any medications, alcohol, tobacco, or other use during pregnancy? _____

Did the baby require medical intervention in the delivery room? Yes No Breast feed? Yes No
Require oxygen? No In delivery room only Longer, how long? _____

How old was the baby when discharged from the nursery? _____