Pediatric Health Care Alliance, P.A.
Your Child's Medical Home™

FAMILY HISTORY *(All patients)*

***Today's Date*: _____**

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **SEX:** ☐M ☐F

Previous Pediatrician Name, City/State *(if any)*: _____

Are there specific concerns you wish to discuss? If so, please explain: _____

_____

PRENATAL HISTORY

Birth weight: _____ Length: _____ Did the infant stay longer than the mother? ☐ Y ☐ N

If so, why?: _____

Did mother have any illness during pregnancy? *(ex: German measles/rubella, flu, bladder/kidney infection)*

Type of infection: _____ *Month of pregnancy:* _____

Medication/treatment: _____

Were there any complications of the pregnancy? *(ex: diabetes, thyroid disease, toxemia, excessive bleeding)*

_____

Were there any complications of the labor or delivery? *(ex: prolonged labor, prematurity, fetal distress, caesarian section, forceps, difficulty in getting baby to breathe)* _____

FAMILY HEALTH HISTORY

Please check all that apply	**Patient's Mother**	**Patient's Father**	**Patient's Sibling**	**Relative** *Please write in*
SKIN: ☐ eczema ☐ psoriasis ☐ ichthyosis	☐	☐	☐	
EYES: ☐ blindness ☐ cataracts ☐ lazy eye	☐	☐	☐	
EARS: ☐ deafness ☐ ear infections ☐ deformities	☐	☐	☐	
NOSE/THROAT: ☐ sinus problems ☐ tonsillitis ☐ lack of sense of smell	☐	☐	☐	
MOUTH: ☐ cleft palate ☐ cleft lip	☐	☐	☐	
GLANDS: ☐ thyroid trouble ☐ diabetes (adult) ☐ diabetes (juvenile)	☐	☐	☐	
LUNGS: ☐ asthma ☐ cystic fibrosis	☐	☐	☐	
HEART: ☐ murmurs ☐ heart attacks ☐ congenital abnormalities ☐ high blood pressure	☐	☐	☐	
STOMACH/BOWEL: ☐ ulcers ☐ colitis ☐ lactose intolerance	☐	☐	☐	
KIDNEY/BLADDER: ☐ congenital abnormalities ☐ infections ☐ kidney stones	☐	☐	☐	
BONE OR JOINT DISEASE: ☐ rheumatoid arthritis ☐ osteoarthritis ☐ osteogenesis imperfecta	☐	☐	☐	
NEUROLOGICAL PROBLEMS: ☐ seizures ☐ paralysis ☐ strokes	☐	☐	☐	
CANCER: ☐ type(s):	☐	☐	☐	
DEVELOPMENT PROBLEMS:	☐	☐	☐	
PSYCHIATRIC: ☐schizophrenia ☐ manic depressive (bipolar) disorder	☐	☐	☐	
OTHER:	☐	☐	☐	