



Willow Bend Pediatrics

Michael J. Frank, M.D., F.A.A.P.
 Susan J. Sickler, M.D., F.A.A.P.
 Shobha Michaels, M.D., F.A.A.P.
 Janet S. Le, M.D., F.A.A.P.
 Tracy Hung, M.D., F.A.A.P.

Medical History Form

Patient: _____ DOB: _____

The patient is a: Male Female

Person completing the form: _____ Relationship: _____

Birth History:

Mother's age at birth _____ Number of weeks gestation: _____

Indicate any medical problems at birth: _____

List any medications taken during pregnancy: _____

Delivery: Vaginal delivery C-section If C-section, list reason: _____

Birth weight: _____ Birth Length: _____ APGAR scores 1 min _____ 5 min _____

Hepatitis B vaccine given: No Yes If yes, date given: _____

Please list any serious problems during the newborn period: None

Medications:

None

Social History:

Parent's Marital Status:

Married Divorced

Safety/Environment:

Are there smokers in the home?

No Yes

Medication Allergies:

None

Who else besides parents
 care for child regularly?

Are there any concerns about lead
 lead exposure? No Yes

Are there any problems with the
 condition of your home? No Yes

Family History: indicate if present in any of your child's parents, siblings, grandparents, aunts/uncles, or first cousins.

<input checked="" type="checkbox"/>	Diagnosis	Family Member	<input checked="" type="checkbox"/>	Diagnosis	Family Member
	ADD/ADHD			High Cholesterol	
	Anemia/Bleeding Disorder			Immune Disorder	
	Asthma/Lung Disorder			Intestinal or Liver Disease	
	Birth Defect			Mental Retardation	
	Cancer			Metabolic/Muscle Disorder	
	Deafness/Hearing Loss			Neurologic Disorder	
	Diabetes			Psychiatric Disorder	
	Eczema/Skin Conditions			Urinary Tract/Kidney Disease	
	Genetic Disease or Syndrome			Seizures	
	Heart Disease/Stroke			Thyroid Issues	
	High Blood Pressure			Tuberculosis	

*** NEWBORNS MAY SKIP REMAINDER OF FORM

Past Medical History:

List any major medical problems: None

List any hospitalizations other than for birth (include reason and date): None

List any serious injuries in the past: None

To the best of my knowledge, my child is up to date on their immunizations: Yes No

If no, Why: _____

Feeding and Nutrition:

History of colic or Reflux?

No Yes

Any unusual feeding/dietary

Problems? No Yes

Development:

At what age did your child:

Sit alone: _____

Walk Alone: _____

Say Words: _____

Dental History:

Has your child been seen
by a dentist: No Yes

Date of last visit:

Review of Systems: Please check any current problems your child has on the list below

General

_____ Fevers/chills/excessive sweating

_____ Unexplained weight loss/gain

Eyes

_____ Squinting/crossed eyes

_____ Asymmetric gaze

Ears/Nose/Throat

_____ Hard of hearing

_____ Mouth breathing/snoring

_____ Chronic runny nose/congestion/sore throat

_____ Problems with teeth/gums

Cardiovascular

_____ Tires easily with exertion

_____ Chest pain

_____ Fainting

_____ Palpitations

Respiratory

_____ Cough/wheeze

_____ Shortness of breath

Gastrointestinal

_____ Abdominal pain/nausea/vomiting/diarrhea

_____ Constipation

_____ Blood in bowel movement

_____ Feeding issues

Genitourinary

_____ Bedwetting

_____ Pain with urination/frequent urination

_____ Discharge: penile or vaginal

Musculoskeletal

_____ Muscle/joint aches or pain

Skin

_____ Rashes

_____ Unusual moles

Neurological

_____ Headaches

_____ Weakness

_____ Clumsiness

Psychiatric/Emotional/Behavioral

_____ Speech problems

_____ Anxiety/Stress

_____ Sleep issues

_____ Depression/suicidal thoughts

_____ Nail biting/thumb sucking

_____ Aggressive or concerning behavior patterns

Blood/Lymph

_____ Unexplained lumps

_____ Easy bruising/bleeding