

# PAST MEDICAL HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Birth:

Hospital \_\_\_\_\_ Date of Birth \_\_\_\_\_

Type of Delivery \_\_\_\_\_ Ht. \_\_\_\_\_ Wt. \_\_\_\_\_

Complications \_\_\_\_\_ Blood Type \_\_\_\_\_

PKU \_\_\_\_\_ Hearing Test Results \_\_\_\_\_

## Hospitalizations:

Reason \_\_\_\_\_ Age \_\_\_\_\_

Reason \_\_\_\_\_ Age \_\_\_\_\_

Reason \_\_\_\_\_ Age \_\_\_\_\_

## Frequent or Recurring Illnesses:

\_\_\_\_\_  
\_\_\_\_\_

## Chronic Medical Problems

Diagnosis \_\_\_\_\_ Meds \_\_\_\_\_

Diagnosis \_\_\_\_\_ Meds \_\_\_\_\_

Diagnosis \_\_\_\_\_ Meds \_\_\_\_\_

## Allergies to Medicines, Pets, Foods, Dust, Molds, Etc.:

Name \_\_\_\_\_ Type Reaction \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Immunizations:

Up to date \_\_\_\_\_ Not up to date \_\_\_\_\_ Brought Shot Record \_\_\_\_\_

## Significant Family Medical History:

\_\_\_\_\_  
\_\_\_\_\_

## Other Concerns:

- |                                  |   |                                   |                                 |
|----------------------------------|---|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Speech  | <input type="checkbox"/> Motor Coordination | <input type="checkbox"/> Behavior | <input type="checkbox"/> Sleep  |
| <input type="checkbox"/> Diet    | <input type="checkbox"/> Bedwetting         | <input type="checkbox"/> School   | <input type="checkbox"/> Weight |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Other _____        |                                   |                                 |

## **NOTICE OF PRIVACY**

I received a copy of the notice of privacy policies for Medical Center Pediatrics.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_