advocare | Broomall Pediatric Associates

MEDICAL HISTORY

NAME **DOB** **TODAYS DATE**

MEDICAL HISTORY OF CHILD

ALLERGIES: Medications:_____

Food:_____ **Pollen/Animals/Etc**_____

Chronic Disease:_____ **Serious Illness:**_____

Hospitalizations:_____ **Fractures:**_____

Surgeries:_____ **Congenital Defects:**_____

Family History: Has any member of your family (including parents, grandparents & siblings) ever had the following?

			Relationship if yes
Allergies	**Yes**	**No**	
Arthritis	**Yes**	**No**	
Attention Deficit Disorder	**Yes**	**No**	
Birth Defects	**Yes**	**No**	
Blood Diseases	**Yes**	**No**	
Cancer (indicate type_____)	**Yes**	**No**	
Diabetes	**Yes**	**No**	
Drug/Alcohol Abuse	**Yes**	**No**	
Heart Attacks	**Yes**	**No**	
Hereditary Syndromes	**Yes**	**No**	
High Blood Pressure	**Yes**	**No**	
Kidney/Bladder Disorders	**Yes**	**No**	
Lung Disease/Asthma	**Yes**	**No**	
Mental Health Conditions	**Yes**	**No**	
Muscle or Bone Disorder	**Yes**	**No**	
Neurological Disorders	**Yes**	**No**	
Obesity	**Yes**	**No**	
Recurrent Infections	**Yes**	**No**	
Seizures	**Yes**	**No**	
Skin Diseases (Cancer/Nevi)	**Yes**	**No**	
STD	**Yes**	**No**	
Strokes	**Yes**	**No**	
Thyroid	**Yes**	**No**	
Tuberculosis	**Yes**	**No**	
Unexplained or Sudden Death	**Yes**	**No**	

Patient's Medications:(Prescription, Over the Counter, Vitamins, Herbs, Etc)

Name	**Dose**	**Take how often**	**Parent Signature**

(see reverse side)

NEW PATIENT: PLEASE GIVE A NURSE/DOCTOR A COPY OF YOUR CHILDS VACCINE HISTORY.
HOW DID YOU HEAR ABOUT OUR PRACTICE?_____

PREGNANCY & DELIVERY:

Place of Birth (Name of Hospital or Birthing Center)_____

Pregnancy Problems_____

Type of Delivery(Vaginal or C-Section)_____

Birth Weight_____Birth Length_____Apgar Screens_____

Newborn Problems_____

DEVELOPMENT:(age if known or put early, normal, etc) For children ages 5 & under only.

Held Up Head_____Rolled Over_____

Sat Alone_____Crawled_____

Walked Holding On_____Walk Alone_____

Runs_____First Words_____

Potty Trained_____

HOME ENVIRONMENT/SAFETY:

Smoker/Active/Passive	**Yes**	**No**	**Type of Heat_____**	**Yes**	**No**
Pets	**Yes**	**No**	**Hot Water Temperature<120°**	**Yes**	**No**
Smoke Detectors/Carbone Monoxide Detector	**Yes**	**No**	**Firearms/Storage/Removal Locked & unloaded**	**Yes**	**No**
Pool/Fence	**Yes**	**No**	**Dental Care 2x yr**	**Yes**	**No**
Sun/Exposure	**Yes**	**No**	**Child Auto Safety**	**Yes**	**No**
Injury Prevention-Window/Stair Guards	**Yes**	**No**	**Lead Exposure-house built prior To 1960**	**Yes**	**No**
Bicycle/Motorcycle/ATV Safety helmets	**Yes**	**No**	**Healthy Diet >5 Fruits/veggies/day**	**Yes**	**No**
Alcohol/Drug Use Chemical Dependency	**Yes**	**No**	**Drug/Poison Storage/Poison Control**	**Yes**	**No**
STD/HIV	**Yes**	**No**	**Choking/CPR Training**	**Yes**	**No**
Contraception	**Yes**	**No**	**Physical Activity >3 x/wk**	**Yes**	**No**