KidMD Pediatrics, LLC

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CHILD'S BIRTH AND HEALTH HISTORY

_____
Child's Name Date of Birth

Was the baby delivered ☐ Vaginal ☐ C-Section

What hospital was the baby born at? _____

_____
Birth Weight Birth Length

Any complications during pregnancy? □ No □ Yes
Was the baby born premature? □ No □ Yes

Did a physician refer you? □ No □ Yes, Physician's name: _____
Are Immunizations up to date? □ No □ Yes
Does the child live with pets? □ No □ Yes
Does anyone smoke in the home? □ No □ Yes
Does the child attend daycare/school? □ No □ Yes
Is your child taking any medications or drugs? □ No □ Yes
If yes, please list: _____

Please list all **ALLERGIES**: _____

Has your child ever been hospitalized? □ No □ Yes, Why _____Year:_____
Has your child ever had surgery? □ No □ Yes, Why _____Year:_____

Which Pharmacy you would like your prescription sent to (phone #)_____
address_____

Do you have any concerns with developmental delays (speech, motor skills, etc.) □ No □ Yes
If yes, Specify please:_____

List the names & ages all the people the child lives with:

NAME	**AGE**	**RELATIONSHIP TO CHILD**
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

Has your child **or** any family members ever **had** any history of **or** difficulty with; any of the following illness?

Child	Family		Child	Family	
□	□	Anemia	□	□	Hypertension
□	□	Asthma	□	□	Hearing problems
□	□	ADD/ADHD	□	□	Joint Problems/Arthritis
□	□	Bed Wetting	□	□	Kidney Disease
□	□	Bladder Infection/UTI	□	□	Lead Poisoning/Exposure
□	□	Bleeding Disorder	□	□	Liver Disease
□	□	Birth Defects	□	□	Mononucleosis
□	□	Cancer	□	□	Pneumonia
□	□	Constipation/Diarrhea	□	□	Smoke/Smokeless Tobacco
□	□	Cerebral Palsy	□	□	Speech Problems
□	□	Chicken Pox	□	□	Sinus Problems
□	□	Depression	□	□	Strep Throat
□	□	Diabetes	□	□	Tuberculosis Exposure
□	□	Drug/Alcohol Abuse	□	□	Vesicoureteral Reflux
□	□	Ear Infections	□	□	Vision Problems
□	□	Eczema	□	□	Other: _____
□	□	Heart Murmur			
□	□	Heart Disease			

In the past week has your **child** experienced any of the following?

Yes	No		Yes	No		Yes	No	
□	□	Headaches	□	□	Decrease Hearing	□	□	Ear Pain
□	□	Head Injury	□	□	Ear Drainage	□	□	Vision Problems
□	□	Weight Gain/loss	□	□	Nose Bleed	□	□	Sore Throat
□	□	Swollen Glands	□	□	Mouth Sores	□	□	Swelling
□	□	Fever	□	□	Nasal Congestion	□	□	Constipation
□	□	Rashes	□	□	Vomiting/Nausea	□	□	Cough
□	□	Short of breath	□	□	Diarrhea	□	□	Wheezing
□	□	Chest Pain	□	□	Pain in urination	□	□	Abdomen Pain
□	□	Seizures	□	□	Weakness/Numbness	□	□	Depression
□	□	Anxiety	□	□	Mood Disorder	□	□	Sleep Disorder
□	□	Muscle Pain	□	□	Itchy Eyes	□	□	Dizziness

Other: _____

The information that I have given is correct to the best of my knowledge. I understand that it will be held in total confidence and it is my responsibility to inform this office of any changes in my minor child's medcial status.

_____

Signature of Parent or Guardian **Date**