

Newborn to Adolescent Medical History Form

Name: _____ Birth date: _____ Sex: M F Today's Date: _____

Form Completed By: _____ Relationship to patient: _____

Child's primary caretaker(s): _____ Legal Guardian(s): _____

Immediate Family Information:

Name	Relationship	Age	Lives in same house?	Marital status	Race	Occupation
	Mother		Yes / No			
	Father		Yes / No			
			Yes / No			
			Yes / No			
			Yes / No			

Birth History:

Birthweight _____ Type of delivery? Vaginal Cesarean Why? _____

Length of pregnancy in weeks _____ Any health problems in mother during pregnancy? _____

Complications during pregnancy? Yes No if yes explain _____

During pregnancy did mother Smoke? Yes No Drink Alcohol? Yes No

Use illicit drugs Yes No If yes what and when: _____

Use any medications? Yes No If yes what and when: _____

Did baby have any problems after birth? Yes No If yes explain: _____

Newborn feeding Breast Formula Hepatitis B vaccine given to baby in hospital? Yes No

Past Medical History:

Does your child take any medications or over the counter supplements regularly: Please list all below with doses:

Medication/Suppliment Name	Dose	How often	Reason for use

Allergies to medications and reactions if known:

Surgeries your child has had with date:

Surgery	Date	Surgeon	Hospital

Immunization History (you may skip this section if full immunization records are available today):

Is your child up to date with all immunizations? yes no unsure

Has your child had the chickenpox vaccine? yes, once yes, twice no unsure

Has your child had the meningitis vaccine (usually as teenagers)? yes no unsure

Has your child had the HPV vaccine (three times, girls only – usually 9-26 years old):? yes no unsure

Continued on back

Patient Sticker

Has your child ever had the flu vaccine (recommended age 6-59 months):? yes no unsure

Has your child ever had the Hepatitis A vaccine?: (recommended from 1-2 year old, encouraged 2-18): yes no

Medical & Family History:

	Patient	Family member (list relationship)	Additional information
Asthma			
Allergies			
Heart Disease before 50 years of age			
Diabetes			
High Blood pressure Before 50 years of age			
High Cholesterol			
Development/ Behavior problems			
Anemia			
Bleeding disorder			
Liver disease			
Kidney disease			
Seizures			
Bedwetting (after 10)			
Alcohol or drug abuse			
Mental illness			
Mental retardation			
Deafness			
Arthritis			
Cancer and type			
Birth defects			
Early childhood death			
Immune problems or HIV or AIDS			
Tuberculosis			
Other			

Tobacco use in home? Yes No Outside use only

Lead Risk: Age of Home _____ Zip Code _____

3/07 tk/jd