HINSDALE PEDIATRIC ASSOCIATES, S.C.

NEW PATIENT MEDICAL HEALTH HISTORY

_____ _____
PATIENT NAME DATE OF BIRTH

_____ _____
PERSON COMPLETING FORM RELATIONSHIP TO PATIENT

SECTION 1 - BIRTH HISTORY (Complete if your child is under age 3)

Birth Weight: _____ Mode of Delivery: Vaginal C-Section

Complications? _____

Length of Pregnancy (number of weeks) _____ Hospital: _____

Complications or illnesses during pregnancy or after delivery _____

_____

SECTION 2 – PAST HOSPITALIZATIONS, SERIOUS ACCIDENTS, OR SURGERIES:

1. Reason/Diagnosis: _____ Date_____
2. Reason/Diagnosis: _____ Date _____
3. Reason/Diagnosis: _____ Date _____

HAS THIS CHILD HAD: (Please circle Yes or No)

Chicken Pox Yes No (If yes, please give month & year) _____

If your child had Chicken Pox, did he/she have more than 10 pox? Yes No

Wheezing/Asthma	Yes No	Seizures/Convulsion	Yes No
Anemia	Yes No	Urinary Tract Infection	Yes No
Lead Poisoning	Yes No		

Any other serious illnesses: _____

Medication patient is currently taking: _____

Please list any known allergies to medication, food, insects or other known allergies and the nature of the reaction (rash/swelling, etc.)

_____

SECTION 3 – Due to genetic pre-disposition of certain diseases, we request your child's ethnic background. Please check all that apply:

	FATHER	MOTHER
African American	◯	◯
Asian/Pacific Islander	◯	◯
Caucasian	◯	◯
Hispanic	◯	◯
Native American	◯	◯

Other (Specify) _____

_____ _____

PATIENT NAME DATE OF BIRTH

SECTION 4 – FAMILY HISTORY

Please circle yes if the child's parents, grandparents, siblings, aunts or uncles have had the following illnesses and indicate the relationship to the child.

Asthma	Yes	_____
Attention Deficit Hyperactive Disorder	Yes	_____
Cancer	Yes	_____
Diabetes	Yes	_____
Hearing Loss/Deafness	Yes	_____
Heart Disease/Heart Attack before age 50	Yes	_____
High Cholesterol	Yes	_____
Hip problems/Hip Dislocations	Yes	_____
Kidney Disease	Yes	_____
Learning Disabilities	Yes	_____
Mental Illness/Anxiety/Depression	Yes	_____
Mental Retardation	Yes	_____
Seizure Disorder/Convulsions	Yes	_____
Stomach/Bowel Disease	Yes	_____
Sudden or unexplained death before age 50	Yes	_____
Thyroid Disease	Yes	_____
Lupus/Autoimmune disease	Yes	_____
Tuberculosis	Yes	_____
Other genetic conditions/diseases	Yes	_____

Section 5 – SAFETY ISSUES

1. Do you and your child wear a helmet and protective gear at all times when biking, rollerblading, skateboarding, and skiing? Yes No
2. Are there any guns in the house? Yes No
3. Does your drinking water have fluoride? Yes No
4. Does your child visit the dentist every 6 months? Yes No
5. Has your child had his vision checked in the past year? Yes No
6. Does your child use a booster seat at all times? Yes No
7. Are there smoke detectors and carbon monoxide detectors in the home? Yes No
8. Is the hot water temperature less than 125 degrees F? Yes No
9. Are all medicines and potential poisons out of reach? Yes No
10. Do you have the poison control number posted? Yes No
11. Do you have a pool at home? Yes No
12. How old is your house? _____
13. Are there any smokers in the household? Who? _____ Yes No
14. Is your child exposed to second hand smoke on a regular basis? Yes No

Section 6 – Misc. Any other information you would like the physician to know about your child

_____

Thank you for taking the time to fill out this form. It will be reviewed by the physician and will become part of the medical record.

TODAY'S DATE _____

REVIEWED BY: _____ DATE OF REVIEW _____