Methodist Medical Group

*Clinic*_____

Today's Date_____

- Child's name_____Birthdate_____Age _____
- Mother's Name_____Father' s Name_____
- Siblings (Names and ages)_____

_____

- Legal guardian (if other than parents)_____
- Who does child live with?_____
- Is this child adopted?_____A foster child?_____
- **Birth History**: At how many weeks of pregnancy was child born?_____Birth weight_____
- Type of delivery: Vaginal_____C-Section_____Type of Anesthesia_____
- List any complications/problems experienced by the mother or infant during pregnancy or delivery_____

_____

- Does this child have any food allergies? Y / N What?_____
- List any **hospitalizations, operations, or procedures** your child has had:

Date	Reason for hospitalization, or name of operation, or procedure

- Has your child had any of the following conditions? Check all that apply

_____Seasonal allergies	_____Eczema	_____Frequent strep throat
_____Asthma	_____Lead poisoning	_____Depression
_____Heart murmur	_____ADD/ADHD	_____Eye problems
_____Urinary tract infection	_____Learning disability	_____Frequent ear infections
_____Frequent stomach pain	_____Constipation	_____Frequent/severe headaches
_____Seizures	_____Bed wetting (over age 6)	_____Sickle cell anemia

- Please list any other illness, conditions, problems, or concerns not listed above:_____

_____

_____

_____

_____

Dept# _____

- List any **medicine** your child takes on a regular basis (include over the counter and herbals)

Medication	Dose	How often?

- Is your child **allergic to any medications**?_____Please list_____

_____

_____

- Does your child have a **latex allergy**? _____
- Are your childs **immunizations** up to date? _____ (Please provide us with a copy.)
- Does anyone your child lives with smoke cigarettes in the home?_____
- **Family History** Please note any family history of the following conditions, and write down their relationship to your child (parent, brother/sister, aunt/uncle, grandparent, cousin).

Seasonal allergies_____ Kidney Disease_____

Bleeding problems_____ Thyroid Disease_____

Asthma_____ Sickle cell trait/disease_____

Cystic Fibrosis_____ Seizures_____

Heart Disease_____ Mental illness/depression_____

Heart attack before the age of 50_____ Arthritis _____

High cholesterol_____ High blood pressure_____

Diabetes_____ Urinary tract infection (in a child)_____

- Please note any other important family history not listed above:_____

_____

_____

_____

- Please note any other concerns you have about your child

_____

_____

_____