PEDIATRIC ASSOCIATES OF ALEXANDRIA, INC.

Pediatric Medical History Form

www.pedsalex.com
Phone: (703) 924-2100 Fax: (703) 922-6067

Child's Name: ______________________________ Birth Date: ______________

DEMOGRAPHICS: Please list pertinent demographic information for legal parents.

	Name	Age	Occupation	Highest Education	Ethnicity
Mother/Parent					
Father/Parent					

	Name	Age		Name	Age
Sibling 1			**Sibling 3**		
Sibilng 2			**Sibling 4**		

FAMILY HISTORY FOR BIOLOGIC FAMILY: Please indicate with a check (√) the specified relatives with any of the following conditions:

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
ADHD												
Anemia												
Autism												
Asthma												
Autoimmune Disease												
Birth Defect (type?)												
Bleeding Problems												
Cancer (type?)												
Depression												
Diabetes												
Eczema												
Endocrine Disease												
Food Allergy (which foods?)												
Genetic Disorder												
Heart Attack/Heart Disease												
Hearing Disorder												
High Cholesterol												
High Blood Pressure												
Immune Disorder												
Kidney Disease												
Learning Disability												
Liver Disease												
Mental Health Problems												
Neurologic Problems												
Seasonal Allergies												
Seizures												
Stroke												
Substance Abuse												
Thyroid Disorders												
Death before age 50												
Other												

Turn over

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Phone:(703) 924-2100 Fax: (703)922-6067

Child's Name:____________________________________ Birth Date:____________________________

BIRTH HISTORY: Please fill in the blanks.

Hospital:____ **Birth Weight (If known)**:__________(lbs)__________(oz)

Type of Delivery:________________________________ **Complications:**________________________________

Term:__________(wks) **Jaundice**: (yes / no) **Phototherapy**: circle one (yes / no)

CHRONIC MEDICATIONS: Please list the child's dose and frequency of chronic medications.

____

____

____

ALLERGIES: Please list any drug and/or food allergies, reaction if ingested, and date first noted.

____

____

PAST MEDICAL HISTORY: Please indicate any chronic conditions or problems of the child.

____

____

SURGERY: Please list any past surgeries and dates.

____

____

HOSPITALIZATION: Please list any past hospitalizations and dates.

____

____

SOCIAL HISTORY: Please answer the following questions.

Who lives in the household?____

____

Does anyone in the household smoke? ______________**If yes, outside or inside?**______________________

Are there any guns in the home? __________________ **If yes, are they locked?**______________________

Are your child's parents married? If not, what is the custody arrangement?____________________________

____