



# Central Florida Pediatrics

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## PATIENT HEALTH HISTORY

Date: \_\_\_\_\_ Child's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Sex:  M  F Race: \_\_\_\_\_ Primary Language: \_\_\_\_\_

### PATIENT HISTORY

Birthplace: \_\_\_\_\_ Hospital: \_\_\_\_\_ OB: \_\_\_\_\_

Delivery:  Vaginal  C-Section Full Term:  Yes  No \_\_\_\_\_ Birth Weight: \_\_\_\_\_

Has the patient ever had (please check all that apply):

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Adenoidectomy     | <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Urinary Infections |
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Chickenpox _____       | <input type="checkbox"/> Mononucleosis        | <input type="checkbox"/> Allergic reaction  |
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Concussion/head injury | <input type="checkbox"/> Nervous Disorders    | to any                                      |
| <input type="checkbox"/> Appendectomy      | <input type="checkbox"/> Chronic ear infections | <input type="checkbox"/> Neurologic Disorders | medications (list):                         |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Pneumonia            | _____                                       |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Ear tubes              | <input type="checkbox"/> Seizure Disorders    | _____                                       |
| <input type="checkbox"/> Broken bone(s)    | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Tonsilectomy         | _____                                       |
| <input type="checkbox"/> Other _____       |   |   |   |

Please list previous physicians familiar with child's medical history: \_\_\_\_\_

### FAMILY HISTORY

	Name	Age	Sex	If living— list all medical conditions	If deceased— list cause of death	Age at death
Father						
Mother						
Sibling			<input type="checkbox"/> M <input type="checkbox"/> F			
Sibling			<input type="checkbox"/> M <input type="checkbox"/> F			
Sibling			<input type="checkbox"/> M <input type="checkbox"/> F			
Sibling			<input type="checkbox"/> M <input type="checkbox"/> F			
Sibling			<input type="checkbox"/> M <input type="checkbox"/> F			

Has anyone in the immediate or extended family had (please check all that apply):

- |  |                    |   |                    |
|--|--------------------|---|--------------------|
| <b><u>Illness</u></b>                          | <b><u>Who?</u></b> | <b><u>Illness</u></b>                         | <b><u>Who?</u></b> |
| <input type="checkbox"/> AIDS                  | _____              | <input type="checkbox"/> High Blood Pressure  | _____              |
| <input type="checkbox"/> Blood Disorders       | _____              | <input type="checkbox"/> Mental disorders     | _____              |
| <input type="checkbox"/> Cancer                | _____              | <input type="checkbox"/> Neurologic disorders | _____              |
| <input type="checkbox"/> Diabetes              | _____              | <input type="checkbox"/> Thyroid problems     | _____              |
| <input type="checkbox"/> Heart Conditions      | _____              | <input type="checkbox"/> Tuberculosis         | _____              |
| <input type="checkbox"/> Hepatitis, Type _____ | _____              | <input type="checkbox"/> Other _____          | _____              |

Does anyone in the household smoke?  Yes  No

Information provided by: \_\_\_\_\_ Relation to child: \_\_\_\_\_



Thank you for providing this information. If there are any items not listed on this form which you feel are pertinent to the care of your child, please feel free to review them during your visit.