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 # Weeks_____ Birth Weight: _____

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

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

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

FAMILY HISTORY

	Name	DOB	Sex	If living– list all medical conditions	If deceased– list cause of death	Age at death
Father						
Mother						
Sibling			☐ M ☐ F			
Sibling			☐ M ☐ F			
Sibling			☐ M ☐ F			
Sibling			☐ M ☐ F			
Sibling			☐ M ☐ F			

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

Illness	**Who?**	**Illness**	**Who?**
☐ AIDS	_____	☐ High Blood Pressure	_____
☐ Blood Disorders	_____	☐ Mental disorders	_____
☐ Cancer	_____	☐ Neurologic disorders	_____
☐ Diabetes	_____	☐ Thyroid problems	_____
☐ Heart Conditions	_____	☐ Tuberculosis	_____
☐ Hepatitis, Type ____	_____	☐ 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.

Child's Name:		DOB:	
Demographic Information			
Parent Last Name	First Name	DOB	Home Phone
Address			Cell Phone
City, State, Zip			Employer
Parent Last Name	First Name	DOB	Home Phone
Address			Cell Phone
City, State, Zip			Employer

Guardian / Step parent information (please circle one)		
Last name	First name	DOB
Last name	First name	DOB
Emergency Contact (Other than the parent of the child)		
Last name	First name	Phone number
Last name	First name	Phone number

Medical staff only below this line	
Hospitalizations/ Surgeries	Allergies
Specialists	Medications