RALEIGH PEDIATRIC ASSOCIATES

MEDICAL HISTORY INFORMATION SHEET

NAME _____ **DOB** _____ **CHART #** _____

FAMILY HISTORY:

FAMILY MEMBER	NAME	DOB	HEALTH PROBLEMS
Father			
Mother			
Sibling(s)			

Any significant history of disease in relatives? _____

_____

Any relatives with sudden death prior to age 50? ___ No ___ Yes **Who?** _____

_____

PERINATAL HISTORY:

Number of:

Pregnancies _____ **Miscarriages** _____ **Abortions** _____

Stillbirths _____ **Premature Births** _____ **Living Children** _____

Age & Cause of Any Child Deaths _____

Patient's Birth Weight _____ **Gestational Age** _____ **Delivery:** ___ **Vaginal** ___ **C-section**

Problems During this Pregnancy/Labor/Delivery _____

_____

PATIENT HISTORY:

PAST MEDICAL HISTORY	NO	YES	COMMENT ON "YES"
Recurrent Illness?			
Medication Allergy?			
Respiratory Allergy?			
Behavior Problems?			
Abnormal Growth or Development?			
Previous Hospitalization?			
On-Going Medication?			
Need to see other Doctors/Consultants?			

Are there problems/concerns that we should be aware of and/or discuss? _____

_____

_____