PATIENT MEDICAL INFORMATION

Name _____ Date of Birth _____ Sex: M____ F____
Last First Middle Month/Day/Year

PERINATAL HISTORY

1. During the pregnancy with this child, did the mother have/take

Regular medical care	[] No	[] Yes	Bleeding problem	[] No	[] Yes	Smoke	[] No	[] Yes
Diabetes	[] No	[] Yes	Infection or illness	[] No	[] Yes	Drink alcohol	[] No	[] Yes
High blood pressure	[] No	[] Yes	Medications	[] No	[] Yes	Use drugs	[] No	[] Yes

Names of medications_____ Names of drugs _____

2. Numbers of pregnancies before this one _____ Total number of living children _____
Name and age of the other children_____

3. Birth: Vaginal delivery_____ Forceps delivery_____ Vacuum delivery_____ Cesarean section_____
Birth weight_____ Birth length_____
Full term_____ Premature_____ Weeks of Gestation _____
Breast feeding_____ Formula fed, Name of Formula_____

4. Newborn: In the hospital, did the baby have problems with:

Infection	[] No	[] Yes	Jaundice	[] No	[] Yes	Seizure	[] No	[] Yes
Breathing problem	[] No	[] Yes	Low blood sugar	[] No	[] Yes	Other problems	[] No	[] Yes

Comment:_____

FAMILY HISTORY

Asthma	[] No	[] Yes	Smoking at home	[] No	[] Yes	Tuberculosis	[] No	[] Yes
Hay fever	[] No	[] Yes	Diabetes	[] No	[] Yes	Cancer	[] No	[] Yes
Eczema	[] No	[] Yes	High cholesterol	[] No	[] Yes	Bleeding problem	[] No	[] Yes
Mental problem	[] No	[] Yes	High blood pressure	[] No	[] Yes	Convulsion	[] No	[] Yes
Alcohol problem	[] No	[] Yes	Heart attack/Stroke	[] No	[] Yes	Neonatal death	[] No	[] Yes
Drug problem	[] No	[] Yes	Sudden death	[] No	[] Yes	Birth defects	[] No	[] Yes

Comment: _____

DEVELOPMENT: At what age did your child first:
Smile_____ Roll over _____ Sit alone _____ Walk alone _____
Say mama or dada _____ Say 2-3 word together _____ Speak in sentences _____ Toilet trained _____
School performance: Good _____ Average _____ Poor _____

IMMUNIZATIONS: **Please attach a copy of your child's immunization record.**

SOCIAL HISTORY: Your child attends day care/ preschool? [] No [] Yes

PAST MEDICAL HISTORY:
Your child: has had a blood lead test? [] No [] Yes, Result: [] Normal [] Abnormal, result _____ on _____; [] Rechecked or [] Treated on _____
takes any medications? [] No [] Yes, names of medications _____
has allergy to any medications? [] No [] Yes ___, names of medications_____
has allergy to anything else (pets, food, etc.)? [] No [] Yes ___ , specify _____
has been admitted to the hospital? [] No [] Yes, Name of the hospital _____, Age ___, Reason _____
has had any of the following:

Chicken pox	[] No	[] Yes	Ear infection	[] No	[] Yes	Hearing problem	[] No	[] Yes
Measles	[] No	[] Yes	Pneumonia	[] No	[] Yes	Speech problem	[] No	[] Yes
Rubella(German measles)	[] No	[] Yes	Urine infection	[] No	[] Yes	Dental problem	[] No	[] Yes
Mumps	[] No	[] Yes	Frequent diarrhea	[] No	[] Yes	Mental problem	[] No	[] Yes
Strep throat	[] No	[] Yes	Constipation	[] No	[] Yes	Heart murmur	[] No	[] Yes
Asthma	[] No	[] Yes	Overweight	[] No	[] Yes	Heart disease	[] No	[] Yes
Eczema	[] No	[] Yes	Underweight	[] No	[] Yes	Anemia	[] No	[] Yes
Hay fever	[] No	[] Yes	Eye problem	[] No	[] Yes	Convulsion	[] No	[] Yes

Comment: Chickenpox at age_____

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Form filled by _____ Reviewed by _____
Parent/Legal Guardian Date Bih-ju Ruby Huang, M.D., F.A.A.P. Date