CRAIG RANCH
PEDIATRICS

Name: ______________________________________ DOB:___________________

Medical History Form

A. Birth History: Birth Weight:______ Birth Length:_______ Obstetrician:_______

Prenatal Problems? __No __Yes (e.g. diabetes, high blood pressure)
Labor/Delivery: __Normal Vaginal Birth __C-section
__Other Problems_______________________________________

Newborn Problems? __No __ Yes (e.g. premature, jaundice, infection)
Hearing Screen: __Pass __Fail
Newborn Screen: __Normal __Abnormal:______________________________

B. Past Medical History:

Date of last check-up:________________ Where? ___________________________
Date of last dental check-up:______________ Where?________________________
Previous Hospitalizations:____
Previous Surgeries:____
Medical Illnesses: (e.g. asthma)____
Allergies: (medications, foods)____
At what age did your child: Sit alone____ Walk____ Talk____ Toilet train_____
Grade in School: ___________________________ Where:_____________________

C. Social & Family History
Household members:

MEMBER	NAME	AGE	SEX	HEALTH	OCCUPATION
Mother					
Father					
Sibs					

Family Medical History: Are any family members with the following diseases?
Asthma, Allergies, Cancer, Seizures, Birth Defects, Heart Disease, Liver Disease, Diabetes, High Blood Pressure, Other. If so, who & which disease____

Home Environment:
Live in: __own house __own apartment __shared home __shared apartment
Smokers in household: __no __yes:_____________________________
Animals in household: __no __yes:_____________________________
Is child in daycare: __no __yes:_____________________________