Northeast Georgia PHYSICIANS GROUP

MEDICAL HISTORY OF A MINOR

FRONT

LAST NAME	FIRST NAME	DATE OF BIRTH	MRN# **(FOR OFFICE USE ONLY)**

Instructions: *Please fill out as completely as possible. All information will be kept confidential. If you have a copy of your child's immunizations, please include it with this form.*

HEALTH CARE STATUS:

Where has your child gone for check-ups until now?

_____

What is the date of your child's last check-up? _____
With whom?_____

What is the date of your child's last dental check-up?_____
With whom?_____

Is your child under treatment for any condition or do they have any recurrent illness? ❑ Yes ❑ No If yes, what? _____

Has your child had any allergic reactions to medications, food or bee stings?
❑ Yes ❑ No If yes, what? _____

Has your child had reactions to immunizations?
❑ Yes ❑ No If yes, what? _____

Has your child had any hospitalizations (other than birth) or had any surgeries or major injuries?
❑ Yes ❑ No If yes, what? _____

Does your child take any medications, including homeopathic meds, herbs or over-the-counter medication such as Tylenol or vitamins?
❑ Yes ❑ No If yes, please list?_____
_____

PREGNANCY AND BIRTH:

Mother's age at birth of this child _____

Did the mother have any illnesses or complications during this pregnancy?
❑ Yes ❑ No If yes, what? _____

Did the mother use any medications other than vitamins?
❑ Yes ❑ No If yes, what? _____

Was the baby born on time? ❑ Yes ❑ No How many weeks? _____

How was the baby born? ❑ Vaginally ❑ C-section ❑ Breech

Did the baby have any trouble starting to breathe? ❑ Yes ❑ No

Did the baby have any trouble while in the hospital (jaundice, infections, breathing problems, etc.)?
❑ Yes ❑ No If yes, what? _____

During this pregnancy, did mother smoke? ❑ Yes ❑ No
Drink alcohol? ❑ Yes ❑ No Use drugs? ❑ Yes ❑ No

What was the baby's birth weight? _____ length? _____

Were there any problems during delivery (antibiotics used, fetal distress, meconium)?
❑ Yes ❑ No If yes, what? _____

Did the baby have any trouble while in the hospital (jaundice, infection, breathing problems)?
❑ Yes ❑ No If yes, what? _____

PAST MEDICAL HISTORY:

Please check if your CHILD has any of the following:

❑ ADD or ADHD
❑ Alcohol or Substance Abuse
❑ Allergies
❑ Anemia
❑ Asthma
❑ Bedwetting after 5 years old
❑ Bladder or Kidney Problems
❑ Blood Diseases
❑ Blood Transfusion
❑ Cancer
❑ Chicken Pox
❑ Congenital Abnormalities
❑ Constipation
❑ Depression
❑ Developmental Delay
❑ Diabetes
❑ Frequent Ear Infections
❑ GE Reflux
❑ Glaucoma
❑ Headaches/Migraines
❑ Heart Murmur
❑ Heart Problems
❑ Hospitalizations other than birth
❑ Menstrual Period Problems
❑ Muscle, Joint or Bone Problems
❑ Seizures/Epilepsy
❑ Thyroid Problems
❑ Tuberculosis
❑ Vision or Eye Problems

Explain More Here: _____

FAMILY HISTORY:

Please list any grandparents, parents or siblings who have:

ILLNESS	RELATIVE
ADD / ADHD	
Alcohol / Substance Abuse	
Anemia	
Anxiety Disorder	
Asthma / Allergies	
Bedwetting after age 10	
Bipolar	
Blood Disease	
Cancer (what kind?)	
Deafness	
Depression	
Development Disorder	
Diabetes	
Epilepsy / Seizures	
Headaches / Migraines	
Heart Disease	
High Blood Pressure	
High Cholesterol	
Immune Problems (HIV/AIDS	
Kidney Disease	
Mental Illness	
Thyroid Problems	
Tuberculosis	

Please list the general health, age and sex of parents, brothers, and sisters.

NAME	GENERAL HEALTH	AGE	SEX

Have any of your children died? ❑ Yes ❑ No

...continued on reverse

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BACK

HOME ENVIRONMENT / SOCIAL HISTORY:

Child's parents are: ❑ Married ❑ Divorced ❑ Separated ❑ Deceased

Child lives with: ❑ Both parents ❑ Mother ❑ Step-father ❑ Father
❑ Step-mother ❑ Joint custody ❑ Guardian ❑ Foster

When not with parents, the child is also in/with:
❑ Day care ❑ Nanny ❑ Relatives ❑ Preschool ❑ School

Is your child adopted? ❑ Yes ❑ No At what age: _____
If yes, do they know they're adopted? ❑ Yes ❑ No

Are there any pets at home? ❑ Yes ❑ No
❑ Dog ❑ Cat ❑ Hamster (or similar) ❑ Reptile ❑ Bird
❑ Other: _____

What type of discipline do you use / works best?
❑ Spanking ❑ Time-out ❑ Redirection ❑ Grounding
❑ Take away something ❑ Other: _____

Any family / peer interaction problems?
❑ Yes ❑ No If yes, please list? _____

Does your child have regular physical / sporting activities?
❑ Yes ❑ No If yes, what? _____

Does your child watch/play > 2 hours of TV/video games daily? ❑ Yes ❑ No

Is your child subjected to passive smoke exposure (off clothes, car, etc.)
❑ Yes ❑ No

Child's caffeine intake: ❑ None ❑ Occasional ❑ Moderate ❑ Heavy

Child's soda intake: ❑ None ❑ Occasional ❑ Moderate ❑ Heavy

Child's alcohol intake: ❑ None ❑ Occasional ❑ Moderate ❑ Heavy

DEVELOPMENT AND BEHAVIOR:

At what age did your child sit alone? _____

At what age did your child walk alone? _____

Did he/she speak any words by age 1½ years? ❑ Yes ❑ No

Did he/she speak any sentences by age 2 years? ❑ Yes ❑ No

Does your child have trouble sleeping? ❑ Yes ❑ No

What grade is your child in? _____
Name of School: _____

Has your child had any trouble in school?
❑ Yes ❑ No If yes, what? _____

Does your child get along well with other children? ❑ Yes ❑ No

Can your child keep up with other children? ❑ Yes ❑ No

Please check if your child has any **persistent** *problems with:*

❑ Bedwetting
❑ Hyperactivity
❑ Nightmares
❑ Problems with discipline
❑ Problems with toilet training
❑ Speech problems
❑ Thumb sucking
❑ Trouble in school
❑ Trouble sleeping

FEEDING AND NUTRITION:

Is your child's appetite usually good? ❑ Yes ❑ No

Meats? ❑ Yes ❑ No Vegetables? ❑ Yes ❑ No Fruits? ❑ Yes ❑ No

Is it good now? ❑ Yes ❑ No

Was there severe colic or any unusual feeding problems in the first 3 months of life?
❑ Yes ❑ No If yes, what? _____

Is/Was your child:
❑ Breast fed (for how long) _____ ❑ Bottle fed ❑ Both

Is your child on a special diet?
❑ Yes ❑ No If yes, what kind? _____

Does your child take vitamins? ❑ Yes ❑ No

Does your child take probiotics? ❑ Yes ❑ No

SAFETY / ENVIRONMENT:

Do you have a:
Pool: ❑ Yes ❑ No Spa: ❑ Yes ❑ No Pond: ❑ Yes ❑ No

Do you keep the hot water heater < 120° F? ❑ Yes ❑ No

Is there a working smoke alarm on each floor at home? ❑ Yes ❑ No

Is there a working carbon monoxide detector on each floor at home?
❑ Yes ❑ No

Does your child always use a seat belt/car seat when in a car? ❑ Yes ❑ No

Does your child wear a helmet when riding a bike/skating? ❑ Yes ❑ No

Are there any smokers in the house? ❑ Yes ❑ No Outside? ❑ Yes ❑ No

Are there any firearms in the home? ❑ Yes ❑ No Locked up? ❑ Yes ❑ No

Have any of the child's caregivers been trained in CPR? ❑ Yes ❑ No

Additional Notes / Comments:

_____

_____

_____

_____

_____

Name of person completing form: _____

Relationship: _____ Date: _____ Provider Signature: _____