

the ChildHealth Center, P.A.

Laura J. Luckadoo, M.D. F.A.A.P.
Angela M. Frierson, M.D. F.A.A.P.
Tatyana V. Golub, M.D. F.A.A.P.
Denise E. Niehues, P.A.-C

Seth A. Abel, P.A.-C
Ann Adams, P.A.-C
Tonya P. Manus, FNP-C
Chassidy C. Howell FNP-C

1455 25th Avenue Dr. NE, Hickory, NC 28601 - Phone: (828) 322-4453 – Fax: (828) 324-9295 - www.thechildhealthcenter.com

MEDICAL HISTORY

NAME OF CHILD _____

1. BIRTH

A. Length of pregnancy _____

B. Mother during pregnancy

1. Age _____

2. Prenatal care: yes _____ no _____ Where? _____

3. Blood type (if known): O _____ A _____ B _____ AB _____ Rh: pos. _____ neg. _____

4. Illnesses (circle and give months that occurred)

a. severe vomiting _____ b. swelling _____

c. increased blood pressure _____ d. vaginal bleeding _____

e. viruses (flu, colds, etc.) _____ f. rashes _____

g. kidney infections _____ h. hospitalizations _____

i. depression _____ j. other _____

5. Total weight gain _____ pounds

6. Drugs taken during pregnancy _____

C. Labor

1. Spontaneous _____ Induced _____

2. Water broke how long before delivery? _____ days _____ hours

3. Fever during labor or week before? Yes _____ No _____

4. Length of labor: _____ hours

5. Known distress of baby during labor? Yes _____ No _____

D. Delivery

1. Type: Vaginal _____ C-section _____

2. Presentation: Vertex (head first) _____ Breech (buttocks first) _____

3. Condition at birth _____

4. Type anesthesia: Gas _____ Spinal _____ Local _____ None _____

5. Birthplace: Hospital _____ City _____ State _____

E. Newborn

1. Birth weight _____

2. Blood type (if known): O _____ A _____ B _____ AB _____ Rh: pos. _____ neg. _____

3. Problems in hospital nursery (respiratory difficulties, jaundice, blueness, convulsions, bleeding, feeding difficulties, deformities, others) Yes _____ No _____

If yes, explain _____

4. Went home on day number: _____

F. Mother's Pregnancy History

1. Total number pregnancies _____

2. Number full term births _____

3. Number weighing less than 5 1/2 pounds _____

4. Stillbirths/miscarriages _____

5. Living children _____

6. This child was pregnancy number _____

7. Difficulties with other pregnancies, labor, delivery, or newborn infants? _____

If yes, explain _____

II. FEEDING

- A. Breast _____ Formula _____ Type _____
1. Weaned from breast at what age? _____
2. Taken off formula at what age? _____
B. Supplemental vitamins Yes _____ No _____ How long? _____
C. Supplemental iron Yes _____ No _____ How long? _____
D. Any feeding problems during first year of life? _____ Explain _____

III. DEVELOPMENT: Age child first performed the following:

- A. Rolled over _____
B. Sat without support _____
C. Stood unassisted _____
D. Acquired first tooth _____
E. Walked alone (more than 4 steps) _____
F. Said first word (other than mama/dada) _____
G. Put two words together (other than bye-bye) _____
H. Bladder control most of time _____ daytime _____ night _____
I. Bowel control most of time _____

IV. ALLERGIES

- List: A. to what substances allergic (ex. Drugs, plants, chemicals, animals, dust, foods, unknown, others) and
B. what type reaction experienced (ex. Asthma, hay fever, eczema, hives, rash, etc.)

A. Allergy:

B. Reaction:

V. ILLNESSES

A. If patient had any of the following illnesses, please give the approximate age and severity or complications.

- | | |
|--|--------------------------|
| 1. Rubeola ("Red" or "Hard" measles) _____ | |
| 2. Rubella ("German" measles) _____ | |
| 3. Chickenpox _____ | 4. Mumps _____ |
| 5. Pneumonia _____ | 6. Rheumatic fever _____ |
| 7. Kidney infections _____ | 8. Other _____ |
| 9. Other _____ | 10. Other _____ |

B. List any illnesses or conditions recurring or persisting for months or years

C. Hospitalizations (other than birth, injuries, or surgery)

<i>Diagnosis</i>	<i>Age</i>	<i>Where</i>	<i>Complications</i>

VI. ILLNESSES

<i>Type</i>	<i>Age</i>	<i>Where Treated</i>	<i>Long-Term Effects</i>

*II. SURGERIES

<i>Type</i>	<i>Age</i>	<i>Where</i>	<i>Complications</i>

DIII. ENVIRONMENT

- A. Water source: City _____ Well _____ Other _____
 B. Pets (list) _____ C. Farm animals (list) _____
 D. Performance in school
 1. Overall achievement: Below average _____ Average _____ Above Average _____
 2. Subject(s) of special difficulty _____ 3. Grades repeated (if any) _____
 E. Behavior _____

IX. FAMILY HISTORY

<i>Member</i>	<i>Name</i>	<i>Year of Birth</i>	<i>Health (if deceased, give cause)</i>
Child's Father			
Child's Mother			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			

Is there any family history of the following (include grandparents, aunts, uncles, 1" cousins):

- | | | |
|---------------------------|---------------------------------|---|
| 1. Asthma (wheezing) | 8. Thyroid disease | 15. Tuberculosis |
| 2. Serious allergies | 9. Liver disease | 16. Cancer |
| 3. Diabetes ("sugar") | 10. Kidney disease | 17. Obesity (overweight) |
| 4. Convulsions (seizures) | 11. Rheumatic fever | 18. High blood pressure |
| 5. Mental retardation | 12. Childhood heart disease | 19. Heart attacks before age 50 |
| 6. Blood disorders | 13. Birth defects | 20. Strokes before age 60 |
| 7. Bleeding tendencies | 14. Death in first year of life | 21. Any other condition occurring in 2 or more family members |

If yes, list the disease or condition below, give relationship of family member to child and specific diagnosis and circumstances (if known).

X. SOCIAL

A. *Interpersonal Relationships* —

Does child have any difficult in relationship with teachers, other family members, classmates? _____

If so, explain _____

B. *Habits* —

Does child have any habits which have been a problem? (thumb sucking, head banging, dirt eating, temper tantrums, nail biting, etc) _____

C. *Sleep* —

Does child have any sleep difficulties? (nightmares, frequent awakening, etc) _____

XI, List any other significant information from the past or present medial history, social situation, or experiences of the patient and his family which might have an effect on his physical or emotional health.

Please explain _____

XII. Additional explanation, clarification, or changes in this form. (Give item number and explain.)

Item #	

Form Initially Completed: Date _____ By _____ Relationship _____