DEKALB HEALTH
MEDICAL GROUP

Pediatric/Adolescent Medical History

Child's Name_____ Nickname: _____ DOB: _____ Grade: _____

Mother's Name _____Occupation: _____ Phone # _____

Father's Name _____Occupation: _____ Phone # _____

Are the child's parents ___ Married ___ Unmarried ___ Separated ___ Divorced ___Widowed

Are there any siblings at home? YES NO Please list names and DOB: _____

_____

This child lives with: _____

Does your child attend daycare? _____ Primary language spoken at home _____

Who takes care of the child during the day or after school? _____

Child's Health History

Birth weight? _____	Please circle: Term	Pre-term Post term
Is child adopted?	YES	NO
Complications with pregnancy?	YES	NO
Hospitalizations immediately after birth?	YES	NO
Has child missed any immunizations?	YES	NO
Has your child ever had surgery?	YES	NO
Other hospitalizations?	YES	NO
Any problems with recurring illnesses?	YES	NO
Any hearing, vision or other disabilities?	YES	NO
Any concerns about your child's development?	YES	NO
Any concerns about your child's behavior?	YES	NO
Has your child ever been seen by a specialist?	YES	NO

If yes to any of the above questions, please explain:

_____

Does your child have any **ALLERGIES** to any medications, foods, or other materials? YES NO

If yes, to what? _____

List **ALL medications** and dosing your child takes (include over the counter meds, vitamins and inhalers) ****Please attach a medication list if there is not enough space provided.**

FAMILY HISTORY

Does anyone in the family have any history of the following?
Please list **child's** mother, father, maternal/paternal grandmother/grandfather, sibling:

High blood pressure	YES	NO	WHO?
High cholesterol	YES	NO	WHO?
Heart disease	YES	NO	WHO?
Stroke	YES	NO	WHO?
Diabetes	YES	NO	WHO?
Thyroid disease	YES	NO	WHO?
Cancer	YES	NO	WHO?
Bleeding/clotting disorder	YES	NO	WHO?
Allergies	YES	NO	WHO?
Asthma	YES	NO	WHO?
Liver disease	YES	NO	WHO?
Kidney disease	YES	NO	WHO?
Seizures	YES	NO	WHO?
Migraines	YES	NO	WHO?
Acid reflux	YES	NO	WHO?
Gastrointestinal disease	YES	NO	WHO?
Mental problems	YES	NO	WHO?
Alcohol problems	YES	NO	WHO?
Drug problems	YES	NO	WHO?
Genetic disorders/Birth defects	YES	NO	WHO?
Autism	YES	NO	WHO?

Safety/Prevention

Does your child wear a seat belt?	YES	NO	
Does your child use a car seat?	YES	NO	N/A
Does your child sit in the back seat?	YES	NO	
Does your child wear protective headgear during certain activities?	YES	NO	
Does your child receive regular dental care?	YES	NO	
Do you having working smoke detectors at home?	YES	NO	
Are there any firearms in the home?	YES	NO	
Is violence at home a concern?	YES	NO	
Is your child exposed to any second-hand smoke?	YES	NO	
Are there any pets at home?	YES	NO	

Do you have any other concerns about your child? _____

_____