PATIENT NAME _____

PATIENT DOB ____/____/____

Holliston Pediatric Group

OFFICES IN HOLLISTON & MILFORD

Medical History Review

Today's date: _____

Your Pediatrician (please circle): Farber Gfeller Kula Kumar Heppen Ryan Urban Vespole Zisblatt

Past Medical History

Any complications with pregnancy or birth? ❍ No ❍ Yes (describe):

Was your child born: ❍ Early ❍ Late ❍ On time Birth weight:

Has your child ever had an allergic reaction to:

Medicine? ❍ No ❍ Yes (describe) _____

Food? ❍ No ❍ Yes (describe) _____

Animals? ❍ No ❍ Yes (describe) _____

Insect bites? ❍ No ❍ Yes (describe) _____

What medications does your child take on a regular basis? _____

Hospitalizations (when/where/why): _____

Surgeries (when/where): _____

Serious injuries (when/where): _____

Other significant past history? _____

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PATIENT DOB _____

Family History

Parents: ❍ Single ❍ Married ❍ Separated ❍ Divorced ❍ Widowed

Mother's age: _____ Mother's health history: _____

Father's age: _____ Father's health history: _____

Sibling (name/age), major medical problems:

1) _____ 3) _____

2) _____ 4) _____

Please check any of the following if present in your family:

- ❍ Anemia/Blood disorder
- ❍ Epilepsy/seizures
- ❍ Asthma/reactive airway disease
- ❍ Allergic rhinitis
- ❍ Heart disease
- ❍ Attention Deficit Disorder (ADD)
- ❍ Depression/Anxiety
- ❍ Drug Problem
- ❍ Alcoholism
- ❍ Cholesterol problem
- ❍ Cancer
- ❍ AIDS
- ❍ Migraine
- ❍ Sudden infant death
- ❍ Birth defects
- ❍ Learning issues/developmental delay
- ❍ Deafness
- ❍ Arthritis
- ❍ Diabetes
- ❍ Thyroid problems

Do any other medical problems/illnesses run in your family? ❍ Yes ❍ No

If yes, please describe: _____

Social History

Who does your child live with: ❍ Mother ❍ Father ❍ Both ❍ Other:

Who else lives at home with your child? _____

Are there any issues you would like to discuss with the health care provider? _____

_____