LITTLETON PEDIATRICS
MEDICAL CENTER, P.C.

Patient History Form

(Please circle your answers. Please elaborate any Yes/positive answers. If more space is needed, please use the back of this form)

Name_____ DOB _____

Patient's Past and Current Medical History

Allergies: No Yes (list) _____

Medications: No Yes (list)_____

_____

Immunizations current? Yes No Not sure (Please provide a copy of your child's immunization record)

Has he/she ever had Chicken Pox? Yes No

Hospitalizations (Please provide dates and reasons why) _____

_____

Pre/Perinatal information: Birthweight _____ Premature? No Yes - how many weeks gestation? _____

Prenatal Problems? No Yes (list) _____

Developmental Problems/issues? No Yes (list)_____

Significant Injuries/Fractures? No Yes (list)_____

Surgeries? No Yes (list)_____

Chronic Medical Conditions/Diagnoses? No Yes (list)_____

Special Diet? No Yes (list)_____

Family History

Father Health issues/problems? No Yes (list)_____

Mother Health issues/problems? No Yes (list)_____

Sib 1 Health issues/problems? No Yes (list)_____

Sib 2 Health issues/problems? No Yes (list)_____

Other Sibs Health issues/problems? No Yes (list; use back if necessary)_____

Aunts' and Uncles' Health issues/problems? No Yes (list)_____

Patient's Cousins Health issues/problems? No Yes (list)_____

Patient's Grandparents Health issues/problems? No Yes (list)_____

Any Family History of the following issues (circle any that apply and please elaborate on the back):

Allergies; Cardiac/Heart disease or arrhythmias; High Blood Pressure; Elevated Cholesterol; Sudden Death; Fainting/Syncope; Asthma; Tuberculosis; Respiratory Diseases; Seizures; Developmental Delays; ADHD; Depression; Other mental health problems; Diabetes; Thyroid Disease; Blood/bleeding/clotting disorders; Problems with Anesthesia; Celiac disease; Inherited/Genetic conditions.

Social History

Adopted? No Yes

Parent's marital status (circle) - Married; Separated; Divorced; Single Other

Father's job/employment _____

Mother's job/employment _____

Is patient in daycare? No Yes

Is patient in school? No Yes Which grade/year/level?_____

Anyone Smoke? No Yes Any Firearms? No Yes

Year home was built, or approximate age of home _____

Water source for home - (circle) City or County; Well; Other

Any Pets? No Yes (list)_____

Any recent International travel? No Yes (where) _____

Date_____Signature _____Relationship to patient_____