SALISBURY PEDIATRIC ASSOCIATES, P.A.

MEDICAL HISTORY INFORMATION SHEET

NAME_____ DOB_____ PATIENT ID#_____

Has your child had any problems with or do you have concerns about any of the following?

MEDICAL HISTORY	NO	YES	COMMENTS ON "YES"
Health in General?			
Skin			
Ears/Nose/Throat			
Breathing			
Heart/Circulation			
Stomach/Digestion			
Muscles/Bones			
Neurological/Development			
Glands/Hormones			
Blood/Bleeding			

PAST MEDICAL HISTORY	NO	YES	COMMENTS ON "YES"
Is he/she allergic to any medications?			
Is he/she allergic to any foods?			
Has your child ever had any surgery?			
Has he/she ever been hospitalized?			
Has he/she had any chronic medical issues?			
Does he/she take medications regularly?			

SOCIAL HISTORY:

Who lives in the house with your child: (Circle all that apply): MOTHER F ATHER BROTHER(S) How many?_____

SISTER(S) How many?_____ STEPMOTHER STEPFATHER GRANDMOTHER GRANDFATHER OTHER_____

BIRTH HISTORY:

BORN (Circle One): VAGINAL C-SECTION BIRTH WEIGHT: _____ lbs _____oz FULL TERM?_____ # OF WEEKS_____

ANY COMPLICATIONS? _____ TYPE:_____

FAMILY MEDICAL HISTORY	NAME	DOB	HEALTH PROBLEMS
Father			
Mother			
Sibling(s)			

Any significant history of disease in relatives?_____

Any relatives with sudden death prior to age 50? _____ No _____ Yes Who? _____