

CORNERSTONE PEDIATRICS
PATIENT MEDICAL / FAMILY HISTORY

Patient's Name:	Child's Date of Birth:	Gender: <i>(circle one)</i> Male Female
Form Completed By:	Your Relation to Patient:	Today's Date:

PREGNANCY AND CHILD'S BIRTH HISTORY

In what city was child born?

At any time, has the child's biological mother been exposed to any of the following?*(check all that apply)*

Hep A Hep B Hep C
 HIV / AIDS Genital Herpes Syphillis
 Rubella Toxoplasmosis

During pregnancy, did the mother use: *(circle all that apply)*
Alcohol Drugs Medications Tobacco Products

Any problems with the birth? No Yes

Describe:

Type of birth: Vaginal or C - Section

Child's birth weight:

Has baby received HepB Vacc? No Yes

Date Hep B vaccine given:

Baby screened for hearing? No Yes

CHILD'S PSYCHOSOCIAL HISTORY

How many members in the child's household?

Parents Siblings Grandparents Ext Fam/Friends

Is your dwelling Owned Rented Temp Shelter

Does child attend: School Homeschool

Does anyone else care for your child?

Who in the household works?

Do you abstain from vaccinating your child? No Yes

Has the child ever been in Foster Care? No Yes

If so, when?

Other languages spoken in the home?

Any Alcohol or Drug Abuse? No Yes

Emotional/Physical/Sexual Abuse? No Yes

Physical Disabilities? No Yes

Learning Disabilities? No Yes

Depression or Suicidal Thoughts? No Yes

FAMILY HISTORY

Has any parent, grandparents, or sibling had:

ADD / ADHD / Learning Disorder	No <input type="radio"/>	Yes <input type="radio"/>
Alcohol and/or Drug Abuse	No <input type="radio"/>	Yes <input type="radio"/>
Allergies	No <input type="radio"/>	Yes <input type="radio"/>

Describe:

Asthma	No <input type="radio"/>	Yes <input type="radio"/>
Cancer	No <input type="radio"/>	Yes <input type="radio"/>
Birth Defects	No <input type="radio"/>	Yes <input type="radio"/>
Blood Disorders/Anemia/Sickle Cell	No <input type="radio"/>	Yes <input type="radio"/>
Diabetes	No <input type="radio"/>	Yes <input type="radio"/>
Family Violence	No <input type="radio"/>	Yes <input type="radio"/>
Hearing Loss / Deafness	No <input type="radio"/>	Yes <input type="radio"/>
Heart Disease	No <input type="radio"/>	Yes <input type="radio"/>
Heptatitis / Liver Disease	No <input type="radio"/>	Yes <input type="radio"/>
High Blood Pressure / Strokes	No <input type="radio"/>	Yes <input type="radio"/>
High Cholesterol	No <input type="radio"/>	Yes <input type="radio"/>
HIV / AIDS	No <input type="radio"/>	Yes <input type="radio"/>
Kidney Disease	No <input type="radio"/>	Yes <input type="radio"/>
Mental Illness	No <input type="radio"/>	Yes <input type="radio"/>
Seizures	No <input type="radio"/>	Yes <input type="radio"/>
Speech Impairments	No <input type="radio"/>	Yes <input type="radio"/>
Thyroid Disease	No <input type="radio"/>	Yes <input type="radio"/>

CHILD'S MEDICAL HISTORY

If female, is patient menstruating? No Yes

Age of menstrual onset:

Had Pregnancy or an abortion? No Yes

Menstrual Problems: No Yes

Allergies - Describe:

Anemia or Diabetes <i>(circle)</i>	No <input type="radio"/>	Yes <input type="radio"/>
Asthma or Bronchitis <i>(circle)</i>	No <input type="radio"/>	Yes <input type="radio"/>
Autism	No <input type="radio"/>	Yes <input type="radio"/>
Bleeding Disorders / Hemophiliaz	No <input type="radio"/>	Yes <input type="radio"/>
Bone or Joint Injury	No <input type="radio"/>	Yes <input type="radio"/>
Frequent Ear Infections	No <input type="radio"/>	Yes <input type="radio"/>
Epilepsy or seizures	No <input type="radio"/>	Yes <input type="radio"/>
Heart Disease / Heart Defects	No <input type="radio"/>	Yes <input type="radio"/>
Hearing or Vision Problems	No <input type="radio"/>	Yes <input type="radio"/>
Hepatitis or Rheumatic Fever	No <input type="radio"/>	Yes <input type="radio"/>
High Blood Pressure	No <input type="radio"/>	Yes <input type="radio"/>
Hospitalized / Surgery	No <input type="radio"/>	Yes <input type="radio"/>
Kidney or Bladder Problems	No <input type="radio"/>	Yes <input type="radio"/>
TB / Lung Disease	No <input type="radio"/>	Yes <input type="radio"/>
Skin Problems / Eczema	No <input type="radio"/>	Yes <input type="radio"/>
Sexually Transmitted Disease	No <input type="radio"/>	Yes <input type="radio"/>

Other: