Pine Grove Pediatrics

Patient's Medical History

Date: / /

Name: _____ **DOB:** ___/___/___

Address: _____ **Age:** _____

_____ **Sex:** M ____ F ____

_____ **Home Phone:** _____

Allergies to Medications, X-Ray Dyes, Food or Other Substances? No ____ Yes ____
(If Yes please list the name of the substances and type of reaction):

_____ _____ _____

_____ _____ _____

Does the Patient Smoke? Y N **If Yes, How Much?** _____

Patient Exposed to Smoking (i.e. in the house)? _____

Past Medical History and Review of Symptoms:
Please circle if the patient has had problems with or are presently complaining of any of the following:

1. High Blood Pressure
2. Diabetes
3. Cancer
4. Heart Disease
5. Palpitations
6. Asthma.Breathing Problems
7. Bronchitis
8. Pneumonia
9. Persistent Cough
10. T.B.
11. Hay Fever
12. Abdominal discomfort
13. Nausea/Vomiting
14. Constipation
15. Diarrhea
16. Ulcers
17. Unexplained Weight Gain/Loss
18. Bowel Problems
19. Hepatitis or Jaundice
20. Thyroid Disease
21. Headaches
22. Kidney Disease
23. Urinary Tract Infection
24. J.R.A.
25. Skin Disease
26. Blood Disorders
27. Veneral Disease
28. Anxiety
29. Depression
30. Anemia (low iron)
31. Alcohol/Drug Abuse
32. Genetic Disorders

_____

_____

Please List and Supply Dates of:

Operations: _____ _____

_____ _____

_____ _____

Hospitalization other than for surgery:

_____ _____

_____ _____

Continued on the back -->

Family's Medical History

Patient Name: _____

Has any member of your family (including parents, grandparents and siblings) ever had the following?

Illness	Which Family Member	Age When Diagnosed
Cancer (describe type)		
Hypertension (High Blood Pressure)		
Heart Disease		
Diabetes		
Strokes		
Mental Disease (anxiety/depression)		
Drug & Alcohol Addiction		
Seizure Disorder		
Bleeding Disorder		
Asthma		
Thyroid Disease		
Urinary Tract Problems		
High Cholestrol		
Other: _____		

Medications (prescribed, over-the-counter, vitamins, herbs etc.)

Drug Name	Dose	Drug Name	Dose

Prevention

Do you wear a seat belt or use car seats?---------- Yes ____ No ____
If No, Why: _____
Do you use a bike helmet?---------- Yes ____ No ____
Does anyone in your family or patient smoke?---------- Yes ____ No ____
If there is a gun in your home, do you keep
it out of reach and unloaded?---------- Yes ____ No ____
Do you have flouride in your water?---------- Yes ____ No ____
Do you have a pool?---------- Yes ____ No ____
Do you live in an older home? (25+ years)---------- Yes ____ No ____
Is there any known risk of lead in your environment?---------- Yes ____ No ____
Does your home have smoke detectors?---------- Yes ____ No ____

This information is for use by your physician as part of your confidential medical record.