Patient History Report

Mid-Florida Pediatrics, P.A.
124 Benmore Drive
Winter Park, FL 32792
Tel (407) 975-0681
Fax (407) 975-0683

Patient Name: ______________________________________ Social Security Number: ______ - ____ - ________

Parents/Legal Guardians: ____

Is the mother's side of the family history known? YES NO Is the father's side of the family history known? YES NO

Please circle any illness that any blood relative has now or had in the past:

seizures	cystic fibrosis	thyroid problems	mental disorders
learning problems	other lung problems	blood disorder	cancer
stroke	asthma	bleeding disorder	digestive problems
attention deficit disorder	bronchitis	depression	diabetes
headaches	heart disorder	alcohol and other drugs	kidney problems
high blood pressure	ulcers	miscarriages or infants die	anyone die under 55 years old

other genetic disorders (please list): ____

Birth History

Any complications during the pregnancy? YES NO

Please check any of the below complications that apply:

□ high blood pressure	□ bleeding	□ trauma during pregnancy
□ excessive vomiting	□ unusual stressors	□ uses of alcohol or other drugs
□ illness during pregnancy	□ smoking (number of packs per day): _____	

Prenatal testing results:

syphilis	□ positive	□ negative	□ do not know or not done
Gonorrhea (GC)	□ positive	□ negative	□ do not know or not done
Chlamydia	□ positive	□ negative	□ do not know or not done
TB	□ positive	□ negative	□ do not know or not done
HIV	□ positive	□ negative	□ do not know or not done
Hepatitis B	□ positive	□ negative	□ do not know or not done

Did you take any medications during your pregnancy? YES NO
If yes, what medications? ____

Where did you get your prenatal care? ____

What month of pregnancy did you start prenatal care? ______

Type of delivery: □ vaginal □ scheduled C/section □ emergency C/section

Was the baby full term? (9 months) YES NO If no, how many weeks old was the baby? _________

Birth Weight: ____________ Length: _____________ head circumference: ___________

Any complications during delivery? YES NO

□ baby didn't cry	□ baby was transferred to another hospital	□ jaundice
□ baby needed CPR	□ baby was sent to a special care unit or NICU	□ other problems
□ oxygen was given	□ baby was given antibiotics in the nursery	□ you had a fever at delivery or right after

Location where your baby was delivered: ___________________________________

Did the baby go home with you? YES NO

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Child's Past History

Please circle yes if your child has now or has had any of the medical problems listed below (please answer all):

chronic illness	YES	NO	school problems	YES	NO	fainting	YES	NO
broken bones	YES	NO	seizures	YES	NO	sickle cell	YES	NO
surgery	YES	NO	depression	YES	NO	diabetes	YES	NO
hospitalized	YES	NO	urinary tract infections	YES	NO	thyroid problems	YES	NO
headaches	YES	NO	bleeding problem	YES	NO	multiple sore throats	YES	NO
ear infections	YES	NO	stomach problems	YES	NO	chicken pox	YES	NO
pneumonias	YES	NO	heart murmur	YES	NO	absent from school for more than 10 days last year	YES	NO
asthma	YES	NO	blood transfusions	YES	NO			

Social History

Household Member Names	Date of Birth	Relationship
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Mother works? YES NO If yes, where: ____________________________________

Father works? YES NO If yes, where: ____________________________________

What city do you live in? ______________________________

You have: city water well water

Pets: YES NO inside outside dog cat bird mice hamster horse snake iguana pig ferret guinea pig chicken other: ________________________

Has your current partner ever hit or threaten you? YES NO

Has any partner in the past ever hit or threaten you? YES NO

What type of discipline do you use at home?

threatening loss of privileges time out discussion
restriction spanking yelling other: ________________

Does anybody smoke in your home? YES NO

Please circle if your child is participating in any of the following:

day care preschool after school program sport

Primary language at home: __________________________

Completed by: ____________________________________ Date: ______________

Staff who reviewed information: ________________________