Lapeer Pediatrics
Patient History

Name:_____DOB:_____Gender: ☐Male ☐ Female
Child Lives with: ☐ Mother ☐ Father ☐ Both Parents ☐ Other:_____

Child's Birth History **(***Check* **X** if *the answer is yes)*

During Pregnancy mother had history of:
- ☐ High blood pressure
- ☐ Gestational Diabetes
- ☐ Sexually transmitted disease
- ☐ Use of Drug
- ☐ Use of Alcohol
- ☐ Smoking

Pregnancy and Delivery:
Pregnancy lasted: _____Weeks
Delivery: ☐ Natural ☐ Cesarean
- ☐ Baby needed Oxygen
- ☐ Baby needed Ventilator if yes How long:____
- ☐ Baby needed Antibiotics
- ☐ Baby had jaundice

Child Past Medical History:
☐ Allergic Reaction to: ☐ Medicine: _____☐ Food:_____ ☐ Latex
(Check all that apply to patient)

☐ Frequent Ear infection	☐ Frequent Sinusitis	☐ Asthma
☐ Frequent throat infection	☐ Frequent Abdominal pain	☐ Heart problem
☐ Pneumonia	☐ Bronchitis	☐ Nasal Allergies(hay fever)
☐ Diarrhea	☐ Constipation	☐ Vomiting
☐ Frequent nosebleeds	☐ Easy to get bruises	☐ Skin problem
☐ Urinary tract infection	☐ Kidney Problem	☐ Bedwetting
☐ Bladder problem	☐ Headaches	☐ Seizures
☐ Diabetes	☐Thyroid problem	☐ Speech Delay
☐ Attention Problem	☐ Learning Difficulties	☐ Other:

Hospitalization or Surgeries*:* *(Date, Reason, Hospital)* _____
_____

Family Medical History:
Next to the Health problem mark as following:
(**F=**Father, **FS=**Father Side, **M=**Mother, **MS=**Mother Side, **S=**Sister, **B=**Brother)

☐ Allergies_____ ☐ Asthma_____☐ Chronic Bronchitis_____
☐ Cancer_____ ☐ Heart Disease_____☐ Tuberculosis_____
☐ Birth Defects_____ ☐ Blood Disease_____☐ Eye Disorder_____
☐ Ear Disorder_____ ☐ Diabetes_____☐ Thyroid disorders_____
☐ Bone or joint Disorders _____☐ Kidney or Bladder Disease _____
☐ Blood Disease _____☐ Rheumatic Disease_____☐ Obesity_____
☐ Cerebral palsy _____☐ Mental retardation _____☐ Epilepsy _____
☐ Alcoholism_____☐ Depression_____☐ Attention disorder_____
☐ Muscular disorder _____ ☐ Sudden Infant Death_____
☐ Other (Specify):_____
_____
Additional data:_____
Patient or Guardian Signature:_____date:_____

Physician Signature:_____date_____