# HEALTHY PEDIATRICS AT OLD BRIDGE, LLC

Date _____

## MEDICAL HISTORY INTAKE FORM

**PATIENT NAME** _____ **DOB** _____

**PRENATAL/BIRTH HISTORY**

A. Mother's Pregnancy: __Normal __Complications:_____
B. Gestation :_____weeks
C. Birth Hospital/Location: _____
D. Delivery: _Vaginal __ C-Section __ Complications: _____
E. Birth Weight: _____lbs_____oz Length:_____inches
F. Discharge Weight:_____lbs_____oz

**PRESENT HEALTH CONCERNS**: Please list most important health concerns in their order of significance

1._____
2._____
3._____

**PAST MEDICAL HISTORY**

MEDICATIONS: Please list prescription medications +/or over the counter medications that you are currently taking, with dosages

1._____ 2._____ 3. _____
4. _____ 5. _____ 6. _____

ALLERGIES: Please include mild to severe or life-threatening allergies and reaction (symptoms)

1. Medications:_____
2. Environment:_____
3. Food:_____

CHILDHOOD ILLNESSES: (Circle and indicate age of illness OR mark C for current as it applies to your child)

Acne: No Yes/Age_____
ADD: No Yes/Age_____
ADHD: No Yes/Age_____
Alcohol use: No Yes/How often:_____
Allergies: No Yes/Age_____
Asthma: No Yes/Age_____
Bedwetting: No Yes/Age_____
Behavior problems: No Yes/Age_____
Bronchitis No Yes/Age_____
Colic: No Yes/Age_____
Constipation: No Yes/How often:_____
Cough: No Yes/How often:_____
Croup: No Yes/Age_____
Depression No Yes/Age_____
Diaper rash: No Yes/How often:_____
Diarrhea: No Yes/How often:_____
Ear Infections: No Yes/How often:_____
Eating Disorders: No Yes/Age and type:_____
Eczema: No Yes/Age:_____
Head lice: No Yes/Age:_____
Molluscum contagiosum: No Yes/Age:_____
Mononucleosis: No Yes/Age:_____
Obesity/Overweight: No Yes/Age:_____
Pink eye: No Yes/Age:_____
Pneumonia: No Yes/Age:_____
Colds: No Yes/How often:_____
Sinus Infection: No Yes/How often:_____
Thrush: No Yes/Age:_____
Vomiting: No Yes/Age:_____
Whooping cough: No Yes/Age:_____
Other: Age:_____Illness:_____
Other: Age:_____Illness:_____

HOSPITALIZATIONS/SURGERIES: (Indicate reason and date)

| Reason for Hospitalization/Surgery | Date |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

SPECIALISTS SEEN: (Indicate reason and date)

| Doctor (including type) | Reason | Date |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

# HEALTHY PEDIATRICS AT OLD BRIDGE, LLC

## MEDICAL HISTORY INTAKE FORM - continued

**PATIENT NAME** _____ **DOB** _____

**FAMILY HISTORY:** Please place a "C" for current or "P" for past in the box next to each condition as it applies to family members of the patient.

| | Mother | Father | Sister | Brother | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather |
|---|---|---|---|---|---|---|---|---|
| ADHD | | | | | | | | |
| Allergies | | | | | | | | |
| Anemia | | | | | | | | |
| Arthritis | | | | | | | | |
| Asthma | | | | | | | | |
| Autism | | | | | | | | |
| Cancer (Include Type) | | | | | | | | |
| Depression | | | | | | | | |
| Diabetes | | | | | | | | |
| Ear Infections | | | | | | | | |
| Eczema | | | | | | | | |
| Epilepsy | | | | | | | | |
| Gastrointestinal DIsease | | | | | | | | |
| Headaches | | | | | | | | |
| Heart Disease | | | | | | | | |
| High Blood Pressure | | | | | | | | |
| High Cholesterol | | | | | | | | |
| Kidney Disease | | | | | | | | |
| Mental Illness | | | | | | | | |
| Reflux | | | | | | | | |
| Stroke | | | | | | | | |

**SOCIAL HISTORY**

Parent's Marital Status: ___ Single ___ Married ___ Divorced ___ Separated

Siblings (Indicate names and ages)

1._____ 4._____ 7._____

2._____ 5._____ 8._____

3._____ 6._____ 9._____

Mother's Occupation:_____ Father's Occupation:_____

SCHOOL: Grade _____

ACTIVITIES: _____

_____

**Form completed by:** _____ **Relation to child**_____

**Reviewed by :**_____ **Date:** _____

**Patricia E. Manfredonia, MD, FAAP**