Bay Pediatric Clinic
Medical History Form

Patient Name: ______________________________
Date of Birth: ______________

Where has your child gone to for check-ups until now? ______________________________

When was your child last dental check-up? ______________________________

List any current medications/vitamins your child is taking: ______________________________

Pregnancy and Birth History

Type of delivery: Vaginal C/Section **Weeks of Gestation:** ________ **Birth Hospital:** ____________

Allergies

Latex: Y N

Medications: ______________________________

Food: ______________________________

Environmental: ______________________________

Social History

Who does the child live with? ______________________________
How many children are in the home? ______________________________
Does the child spend time in more than one household? ______________________________

Does anyone smoke in the home?	Y	N	Working smoke detectors at home?	Y	N
Does the patient use a car/booster seat?	Y	N	Are guns kept in the home?	Y	N
Is there peeling paint in the home?	Y	N	Are guns kept locked or in a safe?	Y	N

Past Personal History (circle all that applies to patient)

Behavioral Problems	Mental Health Problems	Pneumonia	Anemia/Bleeding problems
Arthritis	Eczema	Cancer	Heart Disease
Bed Wetting	Seizures	Headaches	Prematurity
Sepsis	Syncope	Urinary Reflux	Anaphylaxis
Anesthetic Reaction	Asthma	Autism	Cerebral Palsy
Development Delay	Failure to Thrive	Ear Infections	High Blood Pressure
Kidney Problems	Severe Infection	Tobacco Abuse	Urinary Tract Infection

Hospitalizations: ______________________________

Injuries: ______________________________

Surgeries: ______________________________

Past Family History

Please specify which family member and what side of the family **(P for father, M for mother)**
Include: mom, dad, siblings, child's grandparents, child's aunts/ uncles

HIV/AIDS____________	Alcoholism: ____________
Anesthetic Complications: ____________	Asthma: ____________
ADHD: ____________	Autism: ____________
Bleeding Disorder: ____________	Cancer: ____________
Heart Disease: ____________	Celiac Disease: ____________
Cystic Fibrosis: ____________	Crohn's Disease: ____________
Mental Health Problems: ____________	Diabetes: ____________
Down's syndrome: ____________	Seizures: ____________
Fragile X: ____________	Hearing Loss: ____________
High Cholesterol: ____________	High Blood Pressure: ____________
Mental Retardation: ____________	Kidney Problems: ____________
Sickle Cell Anemia: ____________	Ulcerative Colitis: ____________
Arthritis: ____________	Other: ____________