Sunshine Pediatrics of Ocala, P.A.

Medical & Family History Form

Last Name, First Name Birth Date: Male Female

_____ _____/_____/_____

Current Medications: _____

Known Drug/Food Allergies: _____

Birth History: (Please Circle)

Birth weight: _____ Gestation (in weeks): _____

Was the delivery **Vaginal** or **C-Section**? If C-Section, why? _____

Did the mother have any illnesses or problems with her pregnancy? **Explain:** _____

Did the mother take any medications during her pregnancy? **Please List:** _____

Did the mother smoke, drink alcohol or use drugs during her pregnancy? **Explain:** _____

Did the baby have any problems during delivery or right after birth? **Explain:** _____

Past Medical History: Has the patient had any of the following conditions? (Please Check)

□Abdominal Pain
□Acne
□ADD/ADHD
□Allergic Rhinitis
□Anemia
□Asthma
□Autism
□Bedwetting
□Broken Bones (or Fractures)
□Thrush
□Chickenpox
□Concussion
□Constipation
□Convulsions
□Depression
□Diabetes (Type 1)
□Ear Infections
□Eczema
□Elevated Blood Pressure
□Eyes or Vision Problems
□Gastric Reflux
□Headache
□Hearing Loss
□Heart Disease
□Hemophilia
□Hypertension
□Kidney Infection
□Seizure Disorder
□Sickle Cell Anemia
□Thyroid Disorder
□Other: _____
_____
□Unknown

If female, has this patient started her menstrual cycle? Yes No

If so, when? (month/year or approx.age)

_____

Parent's Signature: _____ Date: _____

Past Surgical History: Has the patient had any of the following surgeries? (Please Check)

□Adenoid Removal □Heart Surgery □Unknown

□Appendectomy □Inguinal Hernia Repair

□Broken Bone Repair □Pyloric Stenosis Repair

□Circumcision (if male) □Tonsillectomy

□Club Foot Repair □Umbilical Hernia Repair

□Ear Tube Insertion □Other: _____

Family Medical History: Does anyone in the patient's family have any of the following conditions? (Please remember to include father's side of the family, if known.) (Please Check)

□ADD/ADHD □Diabetes Mellitus (Type 2) □Mental Retardation

□Alcohol Abuse □Diabetes (Juvenile-Type 1) □Migraine Headaches

□Anemia □Drug Abuse □Seizure Disorder

□Asthma □ Epilepsy □Sudden Infant Death Syndrome

□Autism □Hearing Loss □Sudden Unexplained Death (less than 30 yrs old)

□Bedwetting □Heart Disease (less than 50 yrs old) □Tuberculosis (TB)

□Bleeding Disorder □HIV/AIDS □Other: _____

□Blindness □High Cholesterol □Unknown

□Cancer □High Blood Pressure

□Chicken Pox □Thyroid Problem

□Cystic Fibrosis □Kidney Disease

□Deafness □Liver Disease

□Depression □Mental Illness

Social History: (please circle)

Is the child exposed to inside or outside cigar/cigarette smoke? **Yes No** Water Source: **City of Ocala** or **Other Source**

Is the child in foster care? **Yes No** Are parents: **Divorced? Married?** Or **Separated?**

Are there pets in the home? **Yes No** Please List Pets: _____

Who all lives in the child's home (including siblings and significant others)? (Please list below)

_____

Does mother work? **Yes No Profession: _____** Does father work? **Yes No Profession: _____**

Parent's Signature: _____ Date: _____