Lovelace Medical Group

Pediatric Patient Information

Legal Name: Last	First:	☐ Female	☐ Male
Parent or Guardian		DOB:	

Patients Birth History (under the age of 7 years)

Patients Place of Birth:	Birth Weight:	Birth Length:
Illnesses during pregnancy:	Medications during pregnancy:	

Was the baby ☐ Term ☐ Premature ☐ Overdue How much?_____

Delivery ☐ Vaginal ☐ C-section Any problems with the delivery?_____

Did the baby have oxygen after delivery? ☐ Yes ☐ No How long?_____

Did the baby have yellow jaundice? ☐ Yes ☐ No

Did the baby require extra medical attention after delivery? _____

How long was the baby in the hospital? _____

Patients Growth/ Development History

What age did your child: Walk_____ Say sentences_____ Toilet Train_____

If in school: Grade_____ Problems?_____

Any behavior or concentration problems? _____

_____

Medications *(List all current medications including over the counter)*

☐ NO Current Medications

Medication Name	Dosage Strength (i.e.,mg/mcg)	How many times a day?
1		
2		
3		
4		
5		

Allergies

☐ Check box if ther are NO medication allergies.

Drug Name/ Drug Class/ Food	Reaction
1	
2	
3	
4	
5	

Past Medical History

Check all that apply.

☐ Abdominal Pain	☐ Asthma	☐ Constipation	☐ Hearing problems	☐ Prematurity
☐ Acne	☐ Birth trauma	☐ Diabetes	☐ Heart murmur	☐ Pyelonephritis
☐ ADD	☐ Bleeding disorder	☐ Eczema	☐ Menstrual problems	☐ Seizure disorder
☐ ADHD	☐ Bronchitis	☐ Fracture	☐ Micrognathia	☐ Seizures, febrile
☐ Allergic rhinitis	☐ Chickenpox	☐ GERD	☐ Microtia	☐ Urinary tract infection
☐ Allergies	☐ Concussion	☐ Head injury	☐ Otitis media recurrent	☐ Vesicoureteral reflux
☐ Anemia	☐ Congenital heart disease	☐ Headaches	☐ Pneumonia	

Family History

Diagnosis	Circle one	Family Member	Diagnosis	Circle one	Family Member
Alcoholism	No Yes		Gallbladder Disease	No Yes	
Allergies	No Yes		Hyperlipidemia	No Yes	
Alzheimer's Disease	No Yes		Irritable Bowel Synd.	No Yes	
Anxiety/ Depression	No Yes		Liver Disease	No Yes	
Asthma	No Yes		Migraines	No Yes	
Blood Disorders	No Yes		Obesity	No Yes	
CAD	No Yes		Osteoporosis	No Yes	
Cancer (type):	No Yes		Peptic Ulcer Disease	No Yes	
Cardiac Disease	No Yes		Renal Disease	No Yes	
Colitis	No Yes		Rheumatoid Arthritis	No Yes	
Colon Cancer	No Yes		Seizure Disorder	No Yes	
Colon polyps	No Yes		Ulcerative Colitis	No Yes	
Crohn's Disease	No Yes		Other:	No Yes	
CVA	No Yes		Other:	No Yes	
Diabetes	No Yes		Comments:		
Diverticular Disease	No Yes				

Social History

Your answers may help determine your risk for certain diseases. Responses are confidential (13 years or older).

Have you been a victim of… ☐ Physical Abuse ☐ Sexual Abuse

Comments_____

Tobacco Use

Do you… ☐ Smoke a pipe ☐ Chew Tobacco ☐ Smoke Cigarettes ☐ E-sig

How many…

Packs per day? _____

Years? _____

If you quit, what year? _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, what type? _____

If yes, how much? _____

If yes, how often? ☐ Daily ☐ Monthly ☐ Weekly ☐ Occasionally ☐ Rarely

Do you use Illegal drugs? ☐ Yes ☐ No

If yes, what type? _____

If yes, how much? _____

If yes, how often? ☐ Daily ☐ Monthly ☐ Weekly ☐ Occasionally ☐ Rarely

Are you currently pregnant: ☐ Yes ☐ No

Past Surgical History

Describe details of medical conditions in spaces below.

What serious illness has your child had? _____

_____

Any operations? _____

Any serious accidents? _____

Any hospitalizations? _____

Immunizations

Are the Childs immunizations up to date? ☐ Yes ☐ No

Do you have the Childs shot record? ☐ Yes ☐ No

Other? _____

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