RAINBOW PEDIATRICS PATIENT MEDICAL HISTORY FORM

Date	Child's Name	Nickname	DOB	M F
Previous Physician		Request for Records Transfer Complete Y N	Date of Last Well Child Exam	
Mother's Full Name		Father's Full Name		
Step-Mother's Full Name (If Applicable)		Step-Father's Full Name (If Applicable)		
Custodial Provider's Full Name (If different from above)		Relationship to Patient		

Birth History

Birth Weight ________ Preg#______ Mom's age______ Was the birth □ Vaginal? □ Cesarean? □ Early? □ Late?

If birth was early, how many weeks early? ______________ If Cesarean, why? ______________

Did mother have any illnesses/problems with her pregnancy? □ Yes □ No Explain ______________

Did baby have any problems right after birth? □ Yes □ No Explain______________

Before mother knew she was pregnant or at any time during her pregnancy did she:

□ Smoke Cigarettes (amount)______________ □ Drink Alcohol (amount) ______________

□ Use "street" drugs (type)______________ □ Use Prescription Drugs (type)______________

Was initial feeding □ Breast Milk? □ Formula?

Current and Past History

Is your child currently on any medication?	□ Y	□ N	Explain______
Does your child have any serious or chronic illnesses?	□ Y	□ N	Explain______
Has your child had serious injuries or accidents?	□ Y	□ N	Explain______
Has your child had any surgeries?	□ Y	□ N	Explain______
Has your child ever been hospitalized?	□ Y	□ N	Explain______
Is your child allergic to any medications?	□ Y	□ N	Explain______
Has your child ever reacted to immunizations?	□ Y	□ N	Explain______

Does Your Child Have Or Has Your Child Ever Had:

Asthma, recurrent cough, bronchitis, or pneumonia	□ Y	□ N	Explain______
Nasal allergies or eczema	□ Y	□ N	Explain______
Frequent ear infections or sore throat	□ Y	□ N	Explain______
Problems with ears or hearing	□ Y	□ N	Explain______
Problems with eyes, vision or teeth	□ Y	□ N	Explain______
Frequent headaches or other neurologic problems	□ Y	□ N	Explain______
Frequent abdominal pain	□ Y	□ N	Explain______
Constipation requiring doctor visits	□ Y	□ N	Explain______
Bladder/kidney problems or bedwetting	□ Y	□ N	Explain______
Any heart problems/murmur	□ Y	□ N	Explain______
Anemia or bleeding problem	□ Y	□ N	Explain______
Thyroid or other gland problem	□ Y	□ N	Explain______
Diabetes	□ Y	□ N	Explain______
ADD/ADHD	□ Y	□ N	Explain______
Mental Health Issues	□ Y	□ N	Explain______
Use of drugs or alcohol	□ Y	□ N	Explain______

Household Information

Please List All Those Living in the Child's Home		
Name	Relationship to Child	DOB

Are there siblings not listed above? If so, please list their full names and ages and where they live. ____________________

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Child Care:____

Smokers in household? ☐ Y ☐ N

Family Medical History (Parents, Siblings, Grandparents, Aunts and Uncles)				
Have Any Family Members Had the Following:				
Alcohol/Drug Abuse	☐ Y	☐ N	Who________	Comments________
Allergies	☐ Y	☐ N	Who________	Comments________
Asthma	☐ Y	☐ N	Who________	Comments________
Birth Defects	☐ Y	☐ N	Who________	Comments________
Blood Disorders	☐ Y	☐ N	Who________	Comments________
Bone Disorders	☐ Y	☐ N	Who________	Comments________
Cancer	☐ Y	☐ N	Who________	Comments________
Diabetes	☐ Y	☐ N	Who________	Comments________
Endocrine Disease	☐ Y	☐ N	Who________	Comments________
Ear/Nose/Throat Disorders	☐ Y	☐ N	Who________	Comments________
Eye Disorders	☐ Y	☐ N	Who________	Comments________
Gastrointestinal Disorders	☐ Y	☐ N	Who________	Comments________
Heart Disease	☐ Y	☐ N	Who________	Comments________
High Blood Pressure	☐ Y	☐ N	Who________	Comments________
High Cholesterol	☐ Y	☐ N	Who________	Comments________
Immune Disorders	☐ Y	☐ N	Who________	Comments________
Joint Problems	☐ Y	☐ N	Who________	Comments________
Kidney Disease	☐ Y	☐ N	Who________	Comments________
Liver Disease	☐ Y	☐ N	Who________	Comments________
Lung Disease	☐ Y	☐ N	Who________	Comments________
Migraine Headaches	☐ Y	☐ N	Who________	Comments________
Metabolic Disorders	☐ Y	☐ N	Who________	Comments________
Obesity	☐ Y	☐ N	Who________	Comments________
Seizure Disorders	☐ Y	☐ N	Who________	Comments________
Skin Disorders	☐ Y	☐ N	Who________	Comments________
Stroke History	☐ Y	☐ N	Who________	Comments________
Thyroid Disorders	☐ Y	☐ N	Who________	Comments________
Mental Health History	☐ Y	☐ N	Who________	Comments________
Other Medical History	☐ Y	☐ N	Who________	Comments________
Other Medical History	☐ Y	☐ N	Who________	Comments________