Jeffrey S. Feldman, MD

Past Medical History Form

Date_____

Child's Name_____ **Date of Birth**_____

Address_____

Town/City_____ **Zip Code**_____

Birth History: Any problems during pregnancy? Y N _____

Any problems with labor/delivery ? Y N _____

Any problems as a newborn? Y N _____

Birthweight_____ Full-term Premature How many weeks early? _____

Growth and Development:

Any concerns about your child's:

Development ?	Y	N	Physical Growth?	Y	N
Speech ?	Y	N	School Performance?	Y	N
Behavior?	Y	N	Mental Health?	Y	N

Please describe briefly_____

_____

_____

Medical Conditions: Has your child had any medical treatments in past? Y N

Has your child been seen by any specialist doctors? For what problems? Please list.

_____

_____

Has your child been treated by any alternative medicine provider, such as chiropractor, acupuncturist,

Homeopathic doctor, herbalist, or other therapist? Y N Please list.

_____

_____

Allergies: Does your child have any allergies to medicines, foods, animals, plants, indoor allergens? Y N

Allergic to _____ what happens_____

Allergic to _____ what happens_____

Hospitalizations: Has your child ever been in a hospital overnight? Y N

Which Hospital ?_____ Diagnosis ? _____ Year _____

Which Hospital ?_____ Diagnosis ?_____ _____ Year _____

Surgeries: Has your child ever had any surgery/operation? Y N

Which Hospital? _____type of surgery? _____ Year _____

Which Hospital? _____type of surgery? _____ Year _____

Family History: Anyone in the family with any of the following illnesses/conditions? Which relative?

Allergies	Y	N	Asthma	Y	N
Diabetes	Y	N	High Blood Pressure	Y	N
Heart Disease	Y	N	Cancer	Y	N
Mental Illness	Y	N	Learning Problems	Y	N
Seizures	Y	N	Sudden Death	Y	N
Blood Disease	Y	N	Arthritis	Y	N
High Cholesterol	Y	N	Thyroid Disease	Y	N

Social History:

Who lives at home with the child?_____

Any animals in the home? Y N What kind? _____

Any smoking in the home? Y N Who? _____

Is the child in daycare? Y N Where? _____