Elyria Pediatric Care / University Hospitals Medical Practices

Child's Name _____DOB___/___/___ Today's Date___/___/___

Your name:_____Relationship to the child_____

Pregnancy and Birth History	Yes	No		Yes	No
Is this child adopted?	☐	☐	Was the baby early/late (>2weeks)?	☐	☐
Were there any medications taken during pregnancy (other than vitamins)?	☐	☐	Was it a C-section?	☐	☐
			Did the baby have problems at birth?	☐	☐
Any illness during pregnancy?	☐	☐	Any problems breathing?	☐	☐
Use of alcohol during pregnancy?	☐	☐	Was the baby jaundiced?	☐	☐
Use of street drug during pregnancy?	☐	☐	Was the baby breastfed?	☐	☐
Smoking during pregnancy?	☐	☐	Any problems feeding?	☐	☐

Mother's age at delivery?_____ Hospital / City of birth?_____
Baby's birth weight? _____lbs. _____oz

Child's Past Medical History	Yes	No		Yes	No
Any allergies?	☐	☐	Are immunizations delayed?	☐	☐
To medicine?_____	☐	☐	Any medications taken regularly?	☐	☐
To food?_____	☐	☐	Any fractures or serious injuries?	☐	☐
To insect bites?_____	☐	☐	Any serious medical problems?	☐	☐
Anemia?	☐	☐	Ear/Hearing problems?	☐	☐
Asthma/wheezing?	☐	☐	Eye/Vision problems?	☐	☐
Blood transfusions?	☐	☐	Hives?	☐	☐
Cardiac/heart problems?	☐	☐	Migraine headaches?	☐	☐
Chickenpox?	☐	☐	Overweight/underweight?	☐	☐
Chronic ear infections?	☐	☐	Seizures?	☐	☐
Concussion?	☐	☐	Urinary infections?	☐	☐
Eczema?	☐	☐	Any other problems?	☐	☐
Hospitalizations?	☐	☐	If yes, where, when, why?_____		
_____					
Previous primary care physicians?	☐	☐	If yes, who, when?_____		
_____					
Specialty care physicians?	☐	☐	If yes, who, when and why?_____		
_____					

Family Profile

Are the parents: ☐ Married? ☐ Separated? ☐ Divorced? ☐ Single? ☐Widowed?

Father's Name_____ Age_____ In good health?_____
Highest school grade completed? 8th 12th GED Some college College grad Postgrad

Occupation/trade/profession?_____ Employer:_____

Mother's Name_____ Age_____ In good health?_____
Highest school grade completed? 8th 12th GED Some college College grad Postgrad

Occupation/trade/profession?_____ Employer:_____

Child's Name _____DOB___/___/___ Today's Date___/___/___

Who else (siblings, half siblings, step siblings, extended family) lives in the home with this child?

Name_____DOB___/___/___ Relation to child_____

Name_____DOB___/___/___ Relation to child_____

Name_____DOB___/___/___ Relation to child_____

Name_____DOB___/___/___ Relation to child_____

Name_____DOB___/___/___ Relation to child_____

Name_____DOB___/___/___ Relation to child_____

	Yes	No		Yes	No
Does anyone in the home smoke?	□	□	Any pets in the home?	□	□
Any firearms on the home?	□	□	Do you feel safe in your home?	□	□
Any smoke detectors in the home?	□	□	Any carbon monoxide detectors?	□	□
Do your children wear seatbelts?	□	□	Do your children wear bike helmets?	□	□
Do you read to your children?	□	□	Do you have meals together?	□	□

Parent Profile	Yes	No
When you were a child, did either of your parents have a drug or alcohol problem?	□	□
When you were a child, did either of your parents have a mental or chronic illness?	□	□
Where you raised part or all the time by foster parents or relatives (other than parents)?	□	□
Did your parents ground you or put you in time out?	□	□
If yes, how often: □ Frequently □ Occasionally □ Rarely		
Did your parents hit you with an object such as a belt, board, stick or cord?	□	□
If yes, how often: □ Frequently □ Occasionally □ Rarely		
Do you feel that you were physically abused?	□	□
Do you feel that you were neglected?	□	□
Do you feel that you were hurt in a sexual way?	□	□
Did your parents ever hurt you when they were out of control?	□	□
Are you ever afraid that you might lose control and hurt your child?	□	□
In the past year, have you ever had a drinking problem?	□	□
Have you tried to cut down on alcohol in the last year?	□	□
How many drinks does it take for you to get high or get a buzz? □1 □2 □3 □4 □ >4		
Have you ever had a drug problem?	□	□
Have you used any drugs in the last 24 hours?	□	□
If yes, which ones: □ Cocaine □ Speed □ Marijuana □ Heroin □ Methadone		
Are you in a drug or alcohol recovery program now?	□	□
Have you had two or more years in your life when you felt depressed or sad most days, even if you felt okay sometimes?	□	□
In the past year, have you had two weeks or more during which you felt sad, blue, or Depressed, or lost pleasure in things that you usually cared about or enjoyed?	□	□
Would you like more information on parenting classes, support groups and/or hot lines?	□	□

Child's Name _____DOB___/___/___ Today's Date___/___/___

Family Medical History

Use these abbreviations: (F) Father; (M) Mother; (S) Sister; (B) Brother; (MM) Mother's Mother; (MF) Mother's Father; (FM) Father's Mother; (FF) Father's Father; (A) Aunt / a parent's sister; (U) Uncle / a parent's brother; (C) Cousin.

Allergies_____ or □ None
Asthma_____ or □ None
Eczema_____ or □ None

Obesity_____ or □ None
Diabetes (non-insulin dependent)_____ or □ None
Hypertension_____or □ None
High cholesterol_____ or □ None
Early heart attacks (<50 years old)_____ or □ None
Sudden death (unexplained death, drowning, or car accidents)_____ or □ None
Deafness as an infant or child_____ or □ None

ADHD_____or □ None
Depression_____or □ None
Anxiety_____ or □ None
Postpartum depression or anxiety_____ or □ None
Bipolar_____or □ None
Suicide_____or □ None
Alcohol or drug abuse_____or □ None

Thyroid disease_____ or □ None
Diabetes (insulin dependent)_____or □ None
Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)_____ or □ None
Arthritis_____or □ None
Lupus_____ or □ None
Miscarriages_____ or □ None
Celiac disease (gluten sensitivity)_____or □ None

Genetic disease_____ or □ None
Mental retardation_____or □ None
Epilepsy/seizure disorder_____ or □ None
Migraines_____ or □ None
Kidney disease_____ or □ None
Cancer_____ or □ None

IS THERE ANYTHING ELSE THAT YOU WOULD LIKE TO SHARE WITH YOUR DOCTORS?

_____
_____
_____
_____