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____

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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.

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Has your child been treated by any alternative medicine provider, such as chiropractor, acupuncturist, Homeopathic doctor, herbalist, or other therapist? Y N Please list.

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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? ____