PMA: PAST MEDICAL, FAMILY AND SOCIAL HISTORY: AGE BIRTH TO 5 YEARS

Date: _____ **Name**: _____

Patient's Past Medical History

Prior Testing/Developmental Test	None	Yes	Test: _____
Allergies	No	Yes	
Chicken Pox	No	Yes	
Cancer	No	Yes	
Blood/Lymph Disorder	No	Yes	
Diabetes	No	Yes	
Endocrine/Metabolic Disorder	No	Yes	
Nose, Mouth, Throat Disorder	No	Yes	
Cardiovascular Disorder	No	Yes	
Gastrointestinal Disorder	No	Yes	
Genito-urinary/Kidney Disease	No	Yes	
Musculoskeletal Disorder	No	Yes	
Neurologic Disorder	No	Yes	
Psychiatric/Learning Disorder	No	Yes	
Skin Disease	No	Yes	
History of Injury/Trauma	No	Yes	Details: _____

Other Medical History _____

Family Medical History

Please list family member below

Bleeding Disorder	No	Yes	_____
Cancer	No	Yes	_____
Diabetes	No	Yes	_____
Cardiovascular Disorder	No	Yes	_____
Congenital Heart Disease	No	Yes	_____
Eye Disorder	No	Yes	_____
Ear Disorder	No	Yes	_____
Respiratory Disorder	No	Yes	_____
Gastrointestinal Disorder	No	Yes	_____
Musculoskeletal Disorder	No	Yes	_____
Neurologic Disorder	No	Yes	_____
Psychiatric Disorder	No	Yes	_____
SIDS	No	Yes	_____
Skin Disease	No	Yes	_____

Birth History

Birth Location/Hospital			_____
Type of Delivery/Complications	None		_____
Gestational Age	Full Term		_____
Birth Complications	None		_____
Apgar Scores (if known)			_____
Blood Type			_____
Oxygen at Birth	Yes	No	_____
NICU Stay	Yes	No	_____
Synagis given in Hospital	Yes	No	_____
Birth Weight			_____
Discharge Weight			_____
Length at Birth			_____
Head Circumference at Birth			_____
Hepatitis B vaccine give at birth	Yes	No	_____
Mother's Pregnancy Health	Normal	Other	_____

Newborn Screening Test

Newborn Hearing Test	NL	ABN	Not Performed
Newborn State Screen	NL	ABN	Not Performed
Supplemental State Screen	NL	ABN	Not Performed
Other Newborn Screening Test	NL	ABN	Not Performed

Surgical/Hospitalization History

			Details:
Non-Surgical Hospitalizations	No	Yes	_____
Surgical History	No	Yes	_____
Ear Surgery	No	Yes	_____
Nose/Mouth/Throat Surgery	No	Yes	_____
Respiratory Surgery	No	Yes	_____
Cardiovascular Surgery	No	Yes	_____
Gastrointestinal Surgery	No	Yes	_____
Genito-urinary Surgery	No	Yes	_____
Eye Surgery	No	Yes	_____
Orthopedic Surgery	No	Yes	_____
Plastic Surgery	No	Yes	_____

Child Social History

Parent Information: ***(circle all that apply)***

Parents together	Father involved
Lives with mother	Mother involved
Lives with father	Father not involved
Guardian parents	Mother not involved
Same sex partners	Mother/father deceased

Child Care:

Name of Daycare:	_____	
Home with parents	Yes	No
Private home daycare	Yes	No
Sitter to home	Yes	No
Family daycare	Yes	No
Other:	_____	

Home occupants (list all): _____

Parents smokers (circle one): Yes No Outside only

Household Heating/AC type Radiator Forced Hot Air Central/Room Gas Electric

Pets	**#inside**	**# Outside**
None	_____	_____
Dog(s)	_____	_____
Cat(s)	_____	_____
Bird(s)	_____	_____
Reptile(s)	_____	_____
Rodent(s)	_____	_____
Fish	_____	_____

Primary Language in home:

English Spanish Korean Italian Other: _____