

DR. KORDAS PEDIATRIC HEALTH CARE CENTER

FAMILY HISTORY (All patients)

Today's Date: _____

PATIENT NAME: _____ DATE OF BIRTH: _____ SEX: M F

Previous Pediatrician Name, City/State (if any): _____

Are there specific concerns you wish to discuss? If so, please explain: _____

PRENATAL HISTORY

Birth weight: _____ Length: _____ Did the infant stay longer than the mother? Y N

If so, why?: _____

Did mother have any illness during pregnancy? (ex: German measles/rubella, flu, bladder/kidney infection)

Type of infection: _____ Month of pregnancy: _____

Medication/treatment: _____

Were there any complications of the pregnancy? (ex: diabetes, thyroid disease, toxemia, excessive bleeding)

Were there any complications of the labor or delivery? (ex: prolonged labor, prematurity, fetal distress, caesarian section, forceps, difficulty in getting baby to breathe)

FAMILY HEALTH HISTORY

Please check all that apply

	Patient's Mother	Patient's Father	Patient's Sibling	Relative <i>Please write in</i>
SKIN: <input type="checkbox"/> eczema <input type="checkbox"/> psoriasis <input type="checkbox"/> ichthyosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
EYES: <input type="checkbox"/> blindness <input type="checkbox"/> cataracts <input type="checkbox"/> lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
EARS: <input type="checkbox"/> deafness <input type="checkbox"/> ear infections <input type="checkbox"/> deformities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NOSE/THROAT: <input type="checkbox"/> sinus problems <input type="checkbox"/> tonsillitis <input type="checkbox"/> lack of sense of smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MOUTH: <input type="checkbox"/> cleft palate <input type="checkbox"/> cleft lip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
GLANDS: <input type="checkbox"/> thyroid trouble <input type="checkbox"/> diabetes (adult) <input type="checkbox"/> diabetes (juvenile)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
LUNGS: <input type="checkbox"/> asthma <input type="checkbox"/> cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HEART: <input type="checkbox"/> murmurs <input type="checkbox"/> heart attacks <input type="checkbox"/> congenital abnormalities <input type="checkbox"/> high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
STOMACH/BOWEL: <input type="checkbox"/> ulcers <input type="checkbox"/> colitis <input type="checkbox"/> lactose intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
KIDNEY/BLADDER: <input type="checkbox"/> congenital abnormalities <input type="checkbox"/> infections <input type="checkbox"/> kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BONE OR JOINT DISEASE: <input type="checkbox"/> rheumatoid arthritis <input type="checkbox"/> osteoarthritis <input type="checkbox"/> osteogenesis imperfecta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NEUROLOGICAL PROBLEMS: <input type="checkbox"/> seizures <input type="checkbox"/> paralysis <input type="checkbox"/> strokes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CANCER: <input type="checkbox"/> type(s):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
DEVELOPMENT PROBLEMS:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PSYCHIATRIC: <input type="checkbox"/> schizophrenia <input type="checkbox"/> manic depressive (bipolar) disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OTHER:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	