RANKIN Children's Group

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PATIENT MEDICAL HISTORY

Patient Information

Name: DOB: / / Sex: ☐ Male ☐ Female

Form completed by: Date completed: / /

Birth History

Were there any medical problems during pregnancy? ☐ Yes ☐ No

During the pregnancy did the mother ☐ smoke ☐ drink ☐ use drugs ☐ use medication _____

Hospital of Birth: _____

Baby born ☐ term ☐ early ☐ late at _____Weeks The delivery was ☐ Vaginal ☐ C-section Birth Weight: _____

Were there any problems after birth? ☐ Yes ☐ No If yes, explain: _____

_____

_____

Any other important information regarding the birth? ☐ Yes ☐ No If yes, explain: _____

_____

General Medical History

Do you consider the patient to be in good health? ☐ Yes ☐ No Explain: _____

Does the patient have any serious medical conditions? ☐ Yes ☐ No Explain: _____

Has the patient had any serious injuries or accidents ☐ Yes ☐ No Explain: _____

Has the patient ever had surgery? ☐ Yes ☐ No Explain: _____

Has the patient ever been admitted to the hospital? ☐ Yes ☐ No Explain: _____

Is the patient allergic to any medications? ☐ Yes ☐ No Explain: _____

Developmental History

Are you concerned about the patient's physical development? ☐ Yes ☐ No Explain: _____

Are you concerned about the patient's mental or emotional development? ☐ Yes ☐ No Explain: _____

Are you concerned about the patient's attention span? ☐ Yes ☐ No Explain: _____

Are there any concerns related to school (behavior, academics)? ☐ Yes ☐ No Explain: _____

Family History

Is there any significant family history? Please explain (relation, medical problem) _____

_____

_____