acorn PEDIATRICS

Patient Medical History

Patient Name:_____ Date of Birth:_____

Birth History

Birth weight:_____

Where was your child born?_____

Was your child born prematurely (before 37 weeks gestation)? OYes ONo

If yes, how many weeks gestation when born?_____

Did your child develop jaundice? OYes ONo

If yes, was treatment with lights required? OYes ONo

Did your child pass the infant hearing test (older children will not have had this test)? OYes ONo

Was blood collected for the Newborn Screening Test? OYes ONo

Describe any other problems during the newborn period:_____

_____

_____

_____

Medications

Please list any prescription or over-the-counter / herbal medications taken by your child.

_____ _____

_____ _____

_____ _____

Preferred Pharmacy

_____

Allergies

Mark all that apply to this patient:

- O NONE
- O Penicillin (including Amoxicillin and Augmentin)
- O Cephalosporin (including Keflex/Omnicef//Rocephin)
- O Latex
- O Bee Stings
- O Pollen
- O Dust / dust mites
- O Mold
- O Peanuts
- O Other nuts
- O Shellfish
- O Eggs
- O Dairy
- O Wheat
- O Cats
- O Dogs

Other allergies? Please list:_____

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Past Medical Problems

Mark all that apply to this patient:

- O NONE
- O Autism
- O Developmental Delay or Intellectual Disability
- O Ear Infections
- O Speech or Language Delay
- O Constipation
- O Headaches
- O Depression
- O Urinary Tract Infection
- O Asthma
- O ADD/ADHD
- O Gastroesophageal Reflux Disease (GERD)
- O Pneumonia
- O Seizure With fever only? OYes ONo
- O Chronic Abdominal Pain
- O Anxiety
- O Sleep Problems
- O Other?_____

Past Surgery

Mark all that apply to this patient:

- O NONE
- O Tonsillectomy
- O Ear tubes
- O Hernia Repair
- O Appendectomy
- O Circumcision
- O Adenoidectomy
- O Tear Duct Repair
- O Hypospadius Repair
- O Other?_____

Family History

Mark all that apply to the **family members of this patient:**

Problem	Mother	Father	Brother	Sister	Grandmother	Grandfather
Asthma						
Allergies						
Specify:						
Eczema						
Autism						
ADD/ADHD						
Developmental Delay						
Intellectual Disability						
Celiac Disease						
Inflammatory Bowel Disease						
Heart Defect						
Specify:						
Heart Disease						
Diabetes						
High Blood Pressure						
Kidney Disease						
Thyroid Disease						
Anxiety						
Depression						
Alcoholism						
Seizures						
Migraine						
Cancer						
Specify:						
Stroke						

Other?_____

Social History

Tobacco use at home? OYes ONo If yes, Ocigarettes Osnuff
Violence Exposure at home? OYes ONo
School Concerns? OYes ONo
Travel Outside the U.S.? OYes ONo
Guns at home? OYes ONo If yes, stored locked? OYes ONo
Pets at home? OYes ONo
Day Care? OYes ONo