



EAST TENNESSEE
Children's
Hospital

Pediatric Clinic

NEW PATIENT MEDICAL HISTORY

Child's name: _____

M () F ()

Date of birth: / /

BIRTH HISTORY:

Born at (hospital, city and state): _____

Delivery: () vaginal () vacuum assist Gestational age: () full term
 () induced () forceps assist () weeks
 () C-section

Birth weight: _____ Discharge weight (if known): _____

Birth length: _____

Mom's blood type (if known): _____

Infant's blood type (if known): _____

Group B strep status: () pos () neg () unknown

PREGNANCY HISTORY:

Comments:

Pregnancy complications	() yes () no	_____
High blood pressure	() yes () no	_____
Gestational diabetes	() yes () no	_____
Tobacco use	() yes () no	_____
Alcohol use	() yes () no	_____
Other drugs	() yes () no	_____
Birth complications	() yes () no	_____

PAST MEDICAL HISTORY:

Medical issues (such as asthma, seasonal allergies, diabetes, etc.):

Prior hospitalizations: () yes () no Comments: _____

Prior surgeries: () yes () no Comments: _____

Allergies: () NKDA List: _____

Current Medications: (or attach list)	Name	Dosage	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY:

Please indicate if there is a family member with any of the following conditions:

<u>Condition:</u>	Family member(s) affected (specify maternal or paternal):
Asthma	() yes () no _____
Heart disease	() yes () no _____
Heart attack	() yes () no _____
Diabetes	() yes () no _____
Seizures	() yes () no _____
Blood disorders	() yes () no _____
High blood pressure	() yes () no _____
Mental illness	() yes () no _____
Cancer	() yes () no _____
Kidney disease	() yes () no _____
Other disease(s)	() yes () no _____

Comments: _____

() No known health problems in family

Parent/Caregiver signature: _____ Date: / /