105 Collier Road Suite 4060 Atlanta, Georgia 30309 404.351.6662 f 404.351.6030 www.piedmontpediatrics.org

PATIENT HISTORY FORM

Patient's Name: ______________________________

Birth History

Was this child? Full Term Preterm Adopted

If preterm, how many weeks? ______________________________

If adopted, at what age? ______________________________

Birth Weight: ______________________________ Length: ______________________________

Type of delivery: ______________________________

Obstetrician: ______________________________

Did he/she have any problems in the newborn period? ______________________________

Past Medical History

Please circle any illnesses your child has had and list approximate dates and/or frequency:

Anemia	Heart Murmur	Seizures
Asthma	Pneumonia	Strep throat
Chicken Pox	RSV Bronchiolitis	Urinary infections
	Ear infections	Reflux (GERD)

Other: ______________________________

List any surgeries/hospitalizations: ______________________________

List any known allergies: ______________________________

List all medications taken on a regular basis: ______________________________

Family History

Has a family member ever been diagnosed with any of the following?
Please circle and list the relationship. Only include you and the **child's** other parent, siblings, grandparents, aunts, uncles, and cousins.

Anemia	Allergies	Asthma	Bleeding disorder
Cancer	Crohn's disease	Diabetes	Eczema
Emotional problems	Epilepsy	Heart Attack	High blood pressure
High cholesterol	Kidney Disease	Lazy Eye	Psoriasis
Stroke	Thyroid disease	Tuberculosis	Ulcerative Colitis
Unexplained/Sudden Death	Urinary Reflux		

Other ______________________________

If you circled any of the above, please identify the relative: ______________________________.

Is there anything more you would like us to know about your child? ______________________________.

Person completing this form: ______________________________