Sanford Pediatrics, P.A.
Parents and pediatricians are partners

Medical History Information Sheet

Name ______________________________________ DOB: _____________________ Chart # __________________

PERINATAL HISTORY

Number of Pregnancies: ______ Number of Living Children: ______

Age and Cause of Any Child Deaths: _____________________________

Patient Birth Weight: ______ Gestational Age: ______ Delivery: ___ Vaginal ___ C-Section

Problems During Pregnancy/Labor/Delivery: ____

Allergies: ____

Medications: ____

PATIENT HISTORY:

Past Medical History	No	Yes	Comment on "Yes"
Previous Hospitalization?			
Previous Surgeries Under Anesthesia?			
Previous Injuries?			
On-Going Health Problems?			
Recurrent Illness?			
Abnormal Growth or Development?			
Behavior Problems?			
Need to See Other Doctors/Consultants?			

Are there problems/concerns that we should be aware of and/or discuss? ____

____

____

FAMILY HISTORY

Family Member	Name	DOB	Health Problems
Father			
Mother			
Sibling(s)			

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Any significant history of disease in close relatives? ____

____

Any close relatives with sudden death prior to age 50? ___No ___Yes Who? ______________________________

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