Our Children... Our World
McDonough Pediatrics, P.C.
101 Regency Park Drive, Ste 140
McDonough. GA . 30253
Ph - 770-957-8626
Fax - 770-957-7200

Patient's Past Medical, Family, Social History Birth to 5 years

Patient Name:____ **DOB:** ________________

Pharmacy: ____

RACE: (circle One)	White	Black	Native Hawaiian/Pacific Islander		
	Asian		Native American	2 or more Races	Prefer not to disclose
Ethnicity:	Hispanic or Latino		Not Hispanic or Latino		Prefer not to disclose
Preferred Language:	English		Spanish	Other	

Birth History (Children under 3 years):

Birth Location/Hospital:			
Type of Delivery:	Vaginal	C-section	Complications:
Gestational age (premature?)	YES	NO	# of weeks:
Birth Complications:	YES	NO	
Blood Type			
NICU Stay	YES	NO	
Synagis Prophylaxis in hospital?	YES	NO	
Birth weight	lbs.	ozs.	Length:
Discharge weight	lbs.	ozs.	
Head Circumference:	In.		
HepB given at birth	YES	NO	
Mother's Pregnancy health:			
Other remarkable birth hx:			

Patient's Past Medical History:

			Specific Test/Disease Name
Allergies	NO	YES	
History of Chicken Pox	NO	YES	
Cancer	NO	YES	
Blood/Lymph Disorder	NO	YES	
Diabetes	NO	YES	
Endocrine/Metabolic Disorder	NO	YES	
Nose,Mouth, Throat Disordoer	NO	YES	
Cardiovascular Disorder	NO	YES	
GI Disorder	NO	YES	
Kidney Disease	NO	YES	
Musculoskeletal Disorder	NO	YES	
Neurologic Disorder	NO	YES	
Psychiaric/Learning Disorder	NO	YES	
Skin Disease	NO	YES	
History of Injury/trauma	NO	YES	

Family Medical History:

			Please list Specific Family Member
Cancer	NO	YES	
Diabetes	NO	YES	
Eye Disorder	NO	YES	
Ear Disorder	NO	YES	
Respiratory disorder	NO	YES	
GI Disorder	NO	YES	
Musculoskeltal disorders	NO	YES	
Neurologic disorder	NO	YES	
Psychiatric disorder	NO	YES	
Skin Disease	NO	YES	
Other Remarkable Family History:			

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Patient Name:____ **DOB:** _________________

Surgical/Hospitalization History:

			Name of Surgery/details
Non-Surgical Hospitalizations	NO	YES	
Ear Surgery	NO	YES	
Nose/Mouth/Throat Surgery	NO	YES	
Respiratory Surgery	NO	YES	
Cardiovasacular Surgery	NO	YES	
GI Surgery	NO	YES	
GU Surgery	NO	YES	
EYE Surgery	NO	YES	
Orthopedic Surgery	NO	YES	
Plastic Surgery	NO	YES	
Other Surgery	NO	YES	

Child Social History:

Parent Information: (circle all that apply)		OTHER:
Parents together	Father involved	
Lives w/mother	Mother involved	
Lives w/father	Father not involved	
Guardian parents	Mother not involved	
Same sex partners	Mother / Father deceased	

Childcare:	Name of Daycare:					
Home w/parents	YES	NO				
Private Home day care	YES	NO				
Sitter to home	YES	NO				
Family Day Care	YES	NO				
Other:						
How Many People living in home?		#				
Parents Smokers?	YES	NO	Outside Only?			

Pets?	YES	NO	Inside	Outside
Dogs?	#			
Cats?	#			
Birds?	#			
Reptile(s)	#			
Rodent(s)?	#			
Fish?	#			
Other?	#			

Sports/hobbies/activities:	Please circle all that apply					
	None	Ballet/Tap	Gymnastics	Baseball	Football	Soccer
	Track	Band	Cheerleading	Pageant/modeling		Other:_______________

Behavior/ADHD Family History:

Mental Retardation	YES	NO	MEMBER:
Tourette's Syndrome	YES	NO	MEMBER:
Seizures	YES	NO	MEMBER:
ADD/ADHD	YES	NO	MEMBER:
Depression	YES	NO	MEMBER:
Thyroid Diseases	YES	NO	MEMBER:
Schizophrenia	YES	NO	MEMBER:
Mood Disorder	YES	NO	MEMBER:

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