LILLINGTON FAMILY MEDICAL CENTER
CHILD PAST MEDICAL HISTORY

PAST MEDICAL HISTORY

Pharmacy: _____

Chronic Medical Problems: _____

Current Medications: _____

_____

Drug Allergies: _____

Other Allergies: _____

Hospitalizations or Surgeries: _____

Please List Any Specialty Providers Your Child May See: _____

_____

Birth History: (NEWBORN – 6 MONTHS ONLY)
Week's Gestation: _____ Birth Weight: _____ Where Delivered: _____
Delivery Type: _____ Delivery Problems: _____
Neonatal Problems: _____

Vaccines: (*when was your child's last…?)*
Tetanus (Tdap/Td): _____ Flu: _____

Gardasil (HPV): _____ Menactra (Meningitis): _____

SOCIAL HISTORY
Mother: _____ Occupation: _____
Father: _____ Occupation: _____
Smoking in the home? □Y □N School/Daycare: _____ Grade: ____
Child lives with:
□mother/father □mother/stepfather □father/stepmother □grandparents □foster parent/guardian

_____
(please print name of guardian if child does not live with mother and father)

FAMILY HISTORY *If yes, how is family member related to your child, age diagnosed/at death, etc.*

Diabetes	Y	N	
Thyroid Disorder	Y	N	
Lung Disease □*COPD* □*Emphysema* □*Asthma*	Y	N	
Cancer *(what type?)*	Y	N	
Heart Disease	Y	N	
High Blood Pressure	Y	N	
Stroke	Y	N	
Kidney/Urinary Disease	Y	N	
Liver Disease	Y	N	
Gastrointestinal Disease	Y	N	
Alcoholism/Substance Abuse	Y	N	
Mental/Nervous Disorder	Y	N	

Please list any other medical conditions that run in your family: _____
_____

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_____