FAYETTEVILLE
CHILDREN'S CLINIC
P. O. BOX 53127 · FAYETTEVILLE, NC 28305

Past Medical History

NAME _____ (M) (F) DOB: _____ Date: _____

ALLERGIC REACTION

Medicine _____

Food _____

Insect _____

Other _____

HOSPITALIZATIONS / SURGERIES

1. Date/Age: _____
   Hosp: _____
   Dx/Tx: _____
2. Date/Age: _____
   Hosp: _____
   Dx/Tx: _____

Are immunizations up-to-date? _____ Is your child taking any regular medication? _____

Has Development been normal? _____

Any physical or mental handicap? _____

School problems? _____

BIRTH HISTORY

Gestational Age _____

Delivery Weight _____

Type of Delivery _____

PROBLEMS/COMPLICATIONS:

NEONATAL

Infection: _____

Jaundice: _____

Other: _____

FEEDING

Breast _____ , Formula _____

Water supply:

City _____ Well _____ Bottled _____

FAMILY HISTORY

Mother _____ Age _____

Father _____ Age _____

Siblings of the Patient:

1. _____ Age _____
2. _____ Age _____
3. _____ Age _____
4. _____ Age _____

Please check any of the following which occur in the family.

Heart Attack/Stroke _____
Asthma/Eczema/Hay Fever _____
Bleeding Disorder _____
Congenital Heart Disease _____
Cancer _____
Anemia _____
Cystic Fibrosis _____
Mental Retardation _____
Migraine _____
Hypertension _____
Alcoholism/Depression _____

Muscular Dystrophy _____
Diabetes _____
Seizures _____
Arthritis _____
Tuberculosis _____
Sickle Cell _____
SIDS _____
GI Disorder _____
Deafness _____
AIDS _____

Other _____