2025 Technology Parkway, Suite 2018 • Mechanicsburg, PA 17050

PATIENT FAMILY HISTORY

CHILD'S NAME ______________________________ Date of Birth ______________
Last *First* *Middle*

Mother's Name ______________________________ SSN ______________
Last *First*

Father's Name ______________________________ SSN ______________
Last *First*

List all siblings living in the home ______________________________

PRE-NATAL AND BIRTH HISTORY OF CHILD

Pregnancy: Any illnesses or complications? ❑ No ❑ Yes, please explain: ______________

Any smoking, alcohol, or recreational drug use during pregnancy? ❑ No ❑ Yes, please explain:

____

Delivery: Any complications? ❑ No ❑ Yes, please explain: ______________

Baby's Birth Weight: __________ Length: __________ Head: __________ Hospital: __________

Problems at or after birth: ______________________________

Did your baby need any blood transfusions after birth? ❑ No ❑ Yes

CHILD'S ALLERGIES TO

Medications (reaction date and symptoms): ______________________________

Foods: ______________________________

PAST MEDICAL HISTORY OF CHILD

Hospitalizations or outpatient surgeries (when, where and why): ______________________________

____

Serious injuries (when, where): ______________________________

____

Previous MD/Clinic: ______________________________ Dentist: ______________________________

Fluoride: ❑ medication ❑ fluoridated water ❑ none

Has a family member or contact had tuberculosis or a positive tuberculin skin test? ❑ No ❑ Yes

Was your child born in a country at high risk for tuberculosis?
(countries other than the United States, Canada, Australia, New Zealand or Western Europe): ❑ No ❑ Yes

Has your child traveled for longer than one week to a country at high risk for tuberculosis?
(countries other than the United States, Canada, Australia, New Zealand or Western Europe): ❑ No ❑ Yes

Please complete the reverse side

PATIENT FAMILY HISTORY CONTINUED

Your child's previous or current conditions (✓ all relevant)

- ❑ Recurrent ear infection (> 3)
- ❑ Recurrent throat infect. (> 3)
- ❑ Allergies/Sinus problems
- ❑ Asthma/Wheezing
- ❑ Eczema
- ❑ Constipation
- ❑ Chicken Pox
- ❑ Scarlet fever
- ❑ Stomachaches
- ❑ Headaches
- ❑ Seizures
- ❑ Eye problems
- ❑ Hearing problems
- ❑ Kidney/Bladder infections
- ❑ Blood Transfusions
- ❑ Mental/Emotional Problems
- ❑ Cigarette smoker
- ❑ Drug/Alcohol use
- ❑ Tattoos/Body Piercing
- ❑ Other: ______________________________

FAMILY HISTORY OF CHILD: Please indicate the child's blood relatives with the following problems using the abbreviations below:

M – Mother **S** – Sister **MGM** – Mother's Mother **PGM** – Father's Mother **A** – Aunt **C** – Cousin
F – Father **B** – Brother **MGF** – Mother's Father **PGF** – Father's Father **U** – Uncle

AIDS ________	Drug problems ________	Migraine ________
Allergies ________	Eye problems ________	Muscular disease ________
Alcohol problem ________	G.I. Disease ________	Neurological disease ________
Anemia ________	Hearing problems ________	Seizure ________
Asthma ________	Heart attack, age? ________	Skin problems ________
Arthritis ________	Heart disease ________	Sudden death, age? ________
Birth defects ________	High blood pressure ________	Thyroid disease ________
Blindness ________	High cholesterol ________	Tobacco use ________
Cancer, type? ________	Kidney disease ________	Tuberculosis ________
Cystic Fibrosis ________	Learning problems ________	Peptic ulcer ________
Deafness ________	Mental Illness ________	Other ________
Diabetes ________	Mental retardation ________	________

❑ No Significant History

Are there pets in the home? ❑ No ❑ Yes If yes, please list types ______________________________

Are guns kept in the home? ❑ No ❑ Yes If yes, are they securely locked away and inaccessible to children? ❑ Yes ❑ No

Are there additional issues not addressed above of which you would like to make JDC physicians aware? ______________________________

____

Signature of individual completing form: ______________________________ Date: ______________