

Parents, please complete to the  
best of your ability.

**MEDICAL HISTORY FORM**

SILVER LAKE PEDIATRICS  
33017 PROFESSIONAL DRIVE  
LEESBURG FL 34788  
352-314-2275

Person completing this form: \_\_\_\_\_ Date \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Child's primary language: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Child's Primary Care Physician (PCP) Name: \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone ( ) \_\_\_\_\_ Who referred you to this clinic \_\_\_\_\_

**Specific Concerns**

What specifically concerns you about your child? Describe your concerns and what you hope to gain from the evaluation?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When were you first aware of this problem?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child been previously evaluated? By whom? What were you told about your child's problem?

**Composition of Family in which child currently resides:**

Mother's Name \_\_\_\_\_ Age \_\_\_\_\_

Relationship: Biological ☐ Adoptive ☐ Step ☐ Foster ☐ Other ☐ \_\_\_\_\_

Education: \_\_\_\_\_

Occupation: \_\_\_\_\_

Address of Employment: \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Can you be contacted at work? Yes ☐ No ☐ Approximate annual gross income? \_\_\_\_\_

Father's Name \_\_\_\_\_ Age \_\_\_\_\_

Relationship: Biological ☐ Adoptive ☐ Step ☐ Foster ☐ Other ☐ \_\_\_\_\_

Education: \_\_\_\_\_

Occupation: \_\_\_\_\_

Address of Employment: \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Can you be contacted at work? Yes ☐ No ☐ Approximate annual gross income? \_\_\_\_\_

Who is the child's legal guardian? \_\_\_\_\_

Persons residing in the home with child:

Name	Age	Sex	Relationship

If parent works, who cares for child? \_\_\_\_\_

#### Events In Family:

Have any of the following events occurred in the child's immediate family in the past year?

Family moved?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Death, divorce, separation, loss of family member?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Marriage, reconciliation, pregnancy, a new family member?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Serious injury or illness, problems with aging relatives?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Loss of work, change jobs, retirement?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Frequent serious arguments or fights?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Money problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Sex problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Drug or drinking problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Involvement with social services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Out of home placement of the child?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Serious trouble with the law?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mental illness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Some other serious problem?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(If yes, what? _____)		

Agency involved: \_\_\_\_\_ Caseworker: \_\_\_\_\_

Explanation of items marked "yes": \_\_\_\_\_

Is there any history on either side of the child's biologic parents' family of the following? If yes, indicate FATHER'S or MOTHER'S side and explain WHO in remarks section showing the item number.

Item	Item Description	No	Yes	Mother's	Father's	Remarks
1	Psychological/psychiatric emotional					
2	Mental Retardation					
3	Learning Problems					
4	Birth Defects (C.P., etc....)					
5	Seizures/Convulsions					
6	Tuberculosis					
7	Neurological Disease					
8	Diabetes					
9	Cancer					
10	Allergies/asthuna					
11	Gland disorders/thyroid					
12	Hearing disorders					
13	Vision					
14	Hyperactivity					
15	Miscarriages					
16	Slow development					
17	Speech problems					
18	Other diseases in family					

**All Pregnancies (include patient, deceased or miscarriages) in order:**



No.	Birth Weight	Current Age	Current Grade	Health or Developmental Problems/Comments

**Concerning the child being evaluated:**

Did you receive prenatal care? Yes ☐ No ☐

During which month did you start prenatal care? \_\_\_\_\_

Did you smoke cigarettes during your pregnancy? Yes ☐ No ☐ If yes, how many per day? \_\_\_\_\_

Did you drink alcohol during your pregnancy? Yes ☐ No ☐ If yes, number of drinks per week? \_\_\_\_\_

Did you use any narcotic or prescription drugs during or before your pregnancy? Yes ☐ No ☐

If yes, which ones? \_\_\_\_\_ How often? \_\_\_\_\_

Did any of the following occur during pregnancy? (Check those which DID occur)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> decreased fetal movement | <input type="checkbox"/> morning sickness | <input type="checkbox"/> swelling             |
| <input type="checkbox"/> high fever               | <input type="checkbox"/> amniocentesis    | <input type="checkbox"/> stressful events     |
| <input type="checkbox"/> x-rays                   | <input type="checkbox"/> hospitalization  | <input type="checkbox"/> significant trauma   |
| <input type="checkbox"/> ultrasound               | <input type="checkbox"/> operations       | <input type="checkbox"/> special diet         |
| <input type="checkbox"/> stress test              | <input type="checkbox"/> accidents        | <input type="checkbox"/> vaginal bleeding     |
| <input type="checkbox"/> diabetes                 | <input type="checkbox"/> toxemia          | <input type="checkbox"/> unusual worries      |
| <input type="checkbox"/> high blood pressure      | <input type="checkbox"/> premature labor  | <input type="checkbox"/> any other problem(s) |

Please explain the items you checked: \_\_\_\_\_

**Child's Birth**

At birth of child - Mother's age: \_\_\_\_\_ Father's age: \_\_\_\_\_

Place of child's birth: Hospital name: \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Was the baby born on time? \_\_\_\_\_ Late? \_\_\_\_\_ Early? \_\_\_\_\_ How many weeks? \_\_\_\_\_

Any problems with labor or delivery? Yes ☐ No ☐ Explain: \_\_\_\_\_

Type of anesthesia/pain relief/sedation: \_\_\_\_\_

Delivery was by: vaginal/natural \_\_\_\_\_ C-section \_\_\_\_\_ planned \_\_\_\_\_ emergency \_\_\_\_\_ breech \_\_\_\_\_ forceps \_\_\_\_\_

How many days in hospital? \_\_\_\_\_

Infant's condition at birth and in nursery: \_\_\_\_\_

Birth weight: \_\_\_\_\_ Birth length: \_\_\_\_\_ Head Circumference: \_\_\_\_\_

APGAR scores: \_\_\_\_\_

Please explain anything additional or exceptional about the birth or newborn period of your child: \_\_\_\_\_

### Developmental History

Developmental Milestones: State the age when your child first did each of the following. Say "No" if your child has not yet done it. If you do not remember, leave it blank.

Smiled \_\_\_\_\_

Buttoned clothes \_\_\_\_\_

Held head erect \_\_\_\_\_

Dressed self \_\_\_\_\_

Rolled over \_\_\_\_\_

Imitated sound \_\_\_\_\_

Sat alone \_\_\_\_\_

Said "mama", "dada" \_\_\_\_\_

Crawled \_\_\_\_\_

Said other single words \_\_\_\_\_

Walked alone \_\_\_\_\_

Said 2-3 word phrases \_\_\_\_\_

Rode tricycle \_\_\_\_\_

Followed simple directions \_\_\_\_\_

Rode bicycle \_\_\_\_\_

Knew colors \_\_\_\_\_

Ate unaided with spoon \_\_\_\_\_

Started counting \_\_\_\_\_

Separated easily from mother \_\_\_\_\_

Recited total alphabet \_\_\_\_\_

Did you feel your child developed quickly? \_\_\_\_\_

or slowly? \_\_\_\_\_

### Temperament

Please rate the following behaviors as your child appeared during infancy and toddlerhood:

Activity level - How active was your child? \_\_\_\_\_ How distractible? \_\_\_\_\_

Adaptability - How well did your child deal with transition and change? \_\_\_\_\_

Approach/Withdrawal - How well did your child respond to new places, people, and things? \_\_\_\_\_

Intensity - Was your child happy or unhappy? \_\_\_\_\_ Do adults notice how your child is feeling? \_\_\_\_\_

Mood - What was your child's basic mood? (Check one) Happy? ☐ Sad? ☐ Angry? ☐ Quiet? ☐

Regularity - Was your child predictable in patterns of sleep, appetite, etc...?

### Child's Medical History

We need as complete a medical history of your child as possible. Please complete this part. Explain any items checked "YES" in the explanation space and include as much information as possible about the item. Use more paper if necessary.

Has child ever been treated for or had a history of:

No.	Item Description	No	Yes	Explanation
1	Abdominal pain/bowel problems			
2	Allergies, including foods or drugs			
3	Anemia			
4	Birth Defects			
5	Concussion/significant head injury			
6	Dental problems			
7	Drooling			
8	Ear Infections			
9	Eating problems			
10	Headaches			
11	Hearing loss			
12	Heart condition			
13	Hemorrhaging or blood disorders			
14	Hormone problems			
15	Ingesting toxins/poisons			
16	Joint or bone problems			
17	Muscular problems			
18	Seizures or convulsions			
19	Significant accidents			
20	Skin diseases			
21	Tics (eye blinking, any non-purposeful repetitive movement)			
22	Urinary problems or infections			
23	Lung or breathing problems			
24	Visual/eye problems			
25	Other			



Hospitalizations: List any hospitalizations, operations or accidents of child. \_\_\_\_\_

Medications: List medication child currently takes: \_\_\_\_\_

Current Weight \_\_\_\_\_ Current Height \_\_\_\_\_

Has child been immunized? Yes ☐ No ☐ Up to date? \_\_\_\_\_

### **Educational History**

List pre-schools and schools this child has attended:

School:

Dates:

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Has this child ever repeated one or more grades? If so, which grade(s)? \_\_\_\_\_

Has this child ever been in special education, or received resource room help or tutoring?

When

Where

What kind?

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Describe any current school problems: \_\_\_\_\_

Has this child ever received any developmental evaluations or testing in the past?

What type?

Where

What kind?

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Briefly describe this child's attitude toward school:

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Other Information: Please list other items that you may feel are relevant to your child behavior?

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