Cornerstone Pediatrics
Medical History Form

PATIENT NAME:		DATE OF BIRTH:	
ALLERGIES:			
CURRENT DIAGNOSES:			

PATIENT HISTORY: If applicable, please give date and explain.

	Serious Injury/Accident			Eye Condition/Corrective Lenses	
	Surgeries			Problems w. Ears/Hearing	
	Hospitalizations			Skin Problems (acne, eczema, etc)	
	Frequent Ear, Throat, Sinus or Other Infections			Anemia or other Bleeding Problem	
	Allergies			Seizures, Developmental Delays, ADHD, or other Neurological Disorder	
	Asthma/Wheezing			Mental Health Issues or Concerns	
	Heart Murmur or Condition			Orthopedic Problem	
	Abdominal Pain or GI Condition			Diabetes, Thyroid or other Endocrine Problem	
	UTIs or other Urologic Problem			Other Significant Problem	

FAMILY HISTORY: Please specify which family member.

	Allergies			Headaches/Migraines	
	Asthma/Lung Condition			Mental or Developmental Delay	
	Heart Disease or Condition			GI or Liver Disease	
	High Blood Pressure			Kidney Disease	
	High Cholesterol			Hearing Impaired	
	Diabetes, Thyroid or other Endocrine Problem			Vision/Eye Problem	
	Cancer (specify type)			Immune Problem, Recurrent Infections, HIV/AIDS, Etc	
	Anemia or Bleeding Disorder			Drug/Alcohol Abuse	
	Epilepsy, ADHD, or other Neurological Condition			Mental Illness	

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SOCIAL HISTORY/ HOME ENVIRONMENT:			
Lives with Intact Family?			
Non-Intact Custody Status			
Visitation Status of Non-Custodial Parent			
Siblings? How many?			
Any Pets? What kind?	Yes	No	Type:
Any Smokers in the home?	Yes	No	Indoors
Any Guns in the home?	Yes	No	Decline to Answer
Are Guns locked and separate from ammunition?	Yes	No	
PARENTS' STATUS:			
Parents' Marital Status:	Married Divorced Single Other:		
Mother's Occupation:			
Father's Occupation:			

BIRTH HISTORY: (ONLY NECESSARY IF UNDER 1 YEAR)		
Gestational Age:	Birth Wt:	Discharge Wt:
Delivery Method: Vaginal or C-Section	Reason for C-Section:	APGAR Scores:
Hep B Given in Hospital? Yes No	Newborn Hearing Screen: Pass Fail	Birth Hospital/Name of OB/GYN:
Any pregnancy or delivery complications?		