HOMER MEDICAL CENTER
PEDIATRIC DATABASE

Child's Full Name:_____ Nickname_____Date of Birth_____
Mother:_____ home #_____ work #_____
Father:_____ home #_____ work #_____

Please list everyone living in the child's home:

Name	Age	Date of Birth	Relationship to child	Health Problems?

If there are siblings not listed, please list their names, ages and where they live?_____
_____
_____
_____

BIRTH HISTORY

Place of Birth_____ Birth weight_____
Was the baby born at term? _____ Early? _____ Late? _____
Gestational age_____
Did mother have any illness or complications with pregnancy? Yes□ No□
If yes, what?_____
During pregnancy did the mother:
Smoke? Yes□ No□ Drink alcohol? Yes□ No□ Use drugs or medication? Yes□ No□
If yes,what?_____When?_____
What type of delivery? Vaginal □ Cesarean □ If cesarean, why?_____
_____
Did the infant experience any problems right after birth?_____
_____
Did your baby go home with mother from the hospital?_____
If no, please explain._____

PAST MEDICAL HISTORY

Does your child have any serious illness or chronic medical conditions? Yes □ No □
Type, when?_____
Has your child had any serious accidents or injuries? Yes □ No □
Type, when?_____
Has your child had any surgery? Yes □ No □ Explain_____
_____
Has your child ever been hospitalized? Yes □ No □ Explain_____
_____
Is your child allergic to any medicines or drugs? Yes □ No □ Explain_____
_____

FAMILY MEDICAL HISTORY

Please list any family members that have had any of these health problems:

1. Diabetes Yes □ No □ Who_____
2. Heart Disease Yes □ No □ Who_____
3. High Blood Pressure Yes □ No □ Who_____
4. High Cholesterol Yes □ No □ Who_____
5. Cancer Yes □ No □ Who_____
6. Liver Disease Yes □ No □ Who_____
7. Kidney Disease Yes □ No □ Who_____
8. Bleeding Disorders Yes □ No □ Who_____
9. Anemia Yes □ No □ Who_____
10. Deafness Yes □ No □ Who_____
12. Epilepsy or convulsions Yes □ No □ Who_____
13. Bed-wetting (after 10 yrs old) Yes □ No □ Who_____
14. Asthma Yes □ No □ Who_____
15. Nasal allergies Yes □ No □ Who_____
16. ADD/ADHD Yes □ No □ Who_____
17. Tuberculosis Yes □ No □ Who_____
18. Alcohol abuse Yes □ No □ Who_____
19. Drug abuse Yes □ No □ Who_____
20. Domestic violence Yes □ No □ Who_____
21. Mental illness Yes □ No □ Who_____

Mental retardation Yes □ No □ Who_____
Immune Problems, HIV or AIDS Yes □ No □ Who_____
If you answered yes to any of the above, please explain_____
_____
_____
Do any other family members have additional health concerns? (Who and what?)_____
_____
_____