1133 SE 18th Place Suite 1
Ocala, FL 34471
TEL 352.433.2633
FAX 352.433.2644

FASTTRACK PEDIATRICS | NEW PATIENT MEDICAL HISTORY FORM - CHILD

Date	Child's Name	Nickname	DOB	M F
Phone:	Email:		Pharmacy Phone:	
Previous Physician/Office:		Pharmacy Address:		

Mother's Name	Occupation	Age	Father's Name	Occupation	Age

BIRTH HISTORY

Birth Weight:	Preg #	Moms Age:
Was the baby Born on Time? Early? _____ Late?_____		Was the delivery Vaginal?_____ Cesarean?_____
Did mother have any illness or problems with her pregnancy? Y N		Did your baby have any problems after birth? Y N
Smoke during pregnancy. Yes? _____ No?_____		Alcohol during the pregnancy Yes?_____ No?_____
Total Number of Pregnancies:		Number of Live Births:
Pregnancy Complications: Y N	Did baby go home with mother from the hospital? Y N	Initial Feeding? Breast Milk [ ] Formula [ ]

MEDICATIONS

MEDICATIONS *(Please list ALL)*	**DOSE** *(Mg., pill, etc.)*	**TIMES PER DAY**

If you need more room to list medications, please write them on a blank sheet of paper with the required information

ALLERGIES o NO ALLERGIES

ALLERGY	ALLERGIC REACTION

CHILD MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			

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Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

FAMILY MEDICAL HISTORY

o **NO SIGNIFICANT FAMILY HISTORY IS KNOWN**

√ **CHECK ALL THAT APPLY**	Alcohol/Drug Abuse	Asthma	Cancer (type:)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:_____	Other:_____	Other:_____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other:_____																		

HOUSEHOLD INFORMATION

PLEASE LIST ALL THOSE LIVING IN THE CHILD'S HOME		
NAME	**RELATIONSHIP TO CHILD**	**DOB**

Initial Review (Initials/date):

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Patient Name: DOB:

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