Welcome To
Kennesaw Pediatrics
Your Home for Pediatric Healthcare!

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Patient's Medical History

Child's Full Name: _____ Previous Pediatrician: _____

Pregnancy History with Child

Have you had breast surgery? YES ☐ NO ☐
Did you take hormones during pregnancy? YES ☐ NO ☐
Did you take any drugs during pregnancy? YES ☐ NO ☐
Did you smoke during pregnancy? YES ☐ NO ☐
Did you drink any alcoholic beverages during pregnancy? YES ☐ NO ☐
Has the child's mother had any miscarriages, still births, or abortions? YES ☐ NO ☐

Birth History of Child

Please circle one: Full Term Pregnancy ☐ Premature birth: ☐ at ____ weeks
Adopted: at what age? _____ Has he/ been told their adopted? YES ☐ NO ☐
Type of delivery? _____ Obstetrician: _____
Birth Weight: _____ Length: _____ Head Circumference: _____ APGARS: _____
Please circle one: Breast fed ☐ Bottle fed ☐
Any problems at birth? YES ☐ NO ☐ If yes, please specify: _____

Child's Development

Please list age of child when the following milestones were reached:
Sat alone: _____ mos Walked: _____ mos Sentences: _____ mos Words: _____ mos First teeth: _____ mos
Bladder trained: _____ mos Bowel trained: _____ mos
Does the child have any handicap? YES ☐ NO ☐ If yes, please specify: _____
Is there a bed wetting problem? YES ☐ NO ☐ Is there a family history of bed wetting? YES ☐ NO ☐

School Performance

School Performance: Academic: _____
Behavior: _____
Has the child ever been in special education class(es)? YES ☐ NO ☐
Has the child had a learning problem? YES ☐ NO ☐ If yes, please specify what type: _____

Past Illnesses

Please mark date or frequency of illness or specify causing allergy:

Asthma		Pneumonia	
Chicken Pox		Roseola	
Colds		Rubella (German Measles)	
Convulsions		Tonsillitis	
Ear Infections		Scarlet Fever	
Mumps		Urinary Tract Infection	

Allergic to Medication: _____
Allergic to Foods: _____
_____
Allergic to Insect Bites: _____
Has he/she received desensitization shots? YES ☐ NO ☐
Other: _____

Operations and Hospitalizations *Please specify date or reason:*

Appendectomy: _____ Tonsils and Adenoids: _____ Ear Tubes: _____
Other: _____

Medications

Is your child taking any medications on a regular basis? YES ☐ NO ☐
If yes, please specify: _____
Is there anything else about your child you feel we need to know to provide the best medical care for him/her?
Please specify: _____

Name of person completing the form: _____ Relation to patient: _____

Signature: _____ **Patient Name:** _____ **Date:** _____