BLACK HILLS PEDIATRICS, LLP
2905 FIFTH STREET, RAPID CITY, SD 57701
(605) 341-7337

PATIENT MEDICAL HISTORY

PATIENT NAME: _____ TODAY'S DATE: _____

DOB: _____ SEX: □ Male □ Female ADOPTED: □ Yes □ No

BIRTH HISTORY

Birth Weight: _____ Born: □ At Term □ Early □ Late
If early, how many weeks early?_____
Delivery: □ Vaginal □ C-section Problems during Pregnancy? □Yes □ No
Medications During Pregnancy: □ Yes □ No Explain: _____
Alcohol Use? □Yes □ No Tobacco Use? □ Yes □ No Drug Use? □ Yes □ No
Did baby have any problems following delivery? □ Yes □ No Explain: _____
_____
Feeding: □ Breast □ Formula □ Both

GENERAL HEALTH

Do you consider your child to be in good health? □ Yes □ No
Explain: _____
Does your child have any chronic medical problems? □ Yes □ No
Explain: _____
Has your child ever been hospitalized? □ Yes □ No
Explain: _____
Has your child ever had any serious injuries? □ Yes □ No
Explain: _____
Has your child ever had any surgeries? □ Yes □ No
Explain: _____
Is your child allergic to any medications or foods? □ Yes □ No
Explain: _____
Are your child's immunizations up to date? □ Yes □ No □ Unsure
Explain: _____
Is your child currently on any medications? □ Yes □ No
Explain: _____

DEVELOPMENT

Do you have concerns about your child's physical or emotional development? □ Yes □ No
Explain: _____
Is your child doing well in school? □ Yes □ No □ Not applicable Explain: _____
_____
_____
Has your child failed or repeated a grade? □ Yes □ No Explain: _____
_____
Does your child receive special services through the school system? □ Yes □ No
Explain: _____
_____

Please continue on reverse

MEDICAL HISTORY

Has your child had?

Chickenpox	☐Yes ☐ No	Hearing problems	☐ Yes ☐ No
Vision problems	☐Yes ☐ No	Frequent colds	☐ Yes ☐ No
Seasonal/environmental allergies	☐Yes ☐ No	Asthma or chronic cough/wheezing	☐ Yes ☐ No
Heart disease or heart murmur	☐Yes ☐ No	Cancer or leukemia	☐ Yes ☐ No
Blood transfusion	☐Yes ☐ No	Frequent abdominal pain	☐ Yes ☐ No
Constipation	☐Yes ☐ No	Bladder or kidney infection	☐ Yes ☐ No
Chronic skin problems/rashes	☐Yes ☐ No	Frequent headaches	☐ Yes ☐ No
Seizures/neurological problems	☐Yes ☐ No	Diabetes	☐ Yes ☐ No
Thyroid/other endocrine problems	☐Yes ☐ No	Mental health problems	☐ Yes ☐ No
Alcohol/tobacco/drug use	☐Yes ☐ No	Depression	☐ Yes ☐ No

If female, has your child started having periods? ☐Yes ☐ No

Other health issues? ☐Yes ☐ No Explain: _____

_____

FAMILY HISTORY

Have any family members had:

Deafness	☐Yes ☐ No	High blood pressure	☐Yes ☐ No	Diabetes	☐Yes ☐ No
Allergies	☐Yes ☐ No	High cholesterol	☐Yes ☐ No	Epilepsy/Seizures	☐Yes ☐ No
Asthma	☐Yes ☐ No	Anemia	☐Yes ☐ No	Alcohol abuse	☐Yes ☐ No
Heart disease or	☐Yes ☐ No	Bleeding disorder	☐Yes ☐ No	Drug abuse	☐Yes ☐ No
sudden cardiac	☐Yes ☐ No	Liver disease	☐Yes ☐ No	Mental illness	☐Yes ☐ No
death (before age 50)				Mental retardation	☐Yes ☐ No

Explain any "yes" answers: _____

_____

Family Members	Living/ Deceased	Gender	Age (years)	Condition(s) / Notes
Father		N/A		
Mother		N/A		
Paternal grandfather		N/A		
Paternal grandmother		N/A		
Maternal grandfather		N/A		
Maternal grandmother		N/A		
Siblings (1)		☐M ☐ F		
(2)		☐M ☐ F		
(3)		☐M ☐ F		
(4)		☐M ☐ F		
(5)		☐M ☐ F		
Others (aunt/uncle, etc.):		☐M ☐ F		
		☐M ☐ F		
		☐M ☐ F		
		☐M ☐ F		
		☐M ☐ F		

_____ _____

Signature Relation to Patient