DATES UPDATED

Premier Pediatrics of Sumter, LLC

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Patient Medical History

Patient's Name: _____ Date of Birth: _____

Father's Name: _____ Mother's Name: _____

Sibling Name(s) & Age(s): _____

CONDITION	PATIENT	FAMILY	CONDITION	PATIENT	FAMILY	CONDITION	PATIENT	FAMILY
Anemia	❑	❑	Diabetes	❑	❑	Kidney Disease	❑	❑
Autism	❑	❑	Down Syndrome	❑	❑	Liver Disease	❑	❑
ADHD	❑	❑	Drug Abuse	❑	❑	Seizures	❑	❑
Asthma	❑	❑	Genetic Disease	❑	❑	Skin Disease	❑	❑
Birth Defects	❑	❑	Headaches	❑	❑	Strokes	❑	❑
Bleeding Disorders	❑	❑	Hearing Loss	❑	❑	Thyroid Disease	❑	❑
Cancer	❑	❑	Heart Disease	❑	❑	Tuberculosis	❑	❑
Cerebral Palsy	❑	❑	High Cholesterol	❑	❑	Ulcers	❑	❑
Depression	❑	❑	High Blood Pressure	❑	❑	Other (list)	❑	❑

Explain Positive Responses (if needed):

_____

_____

Past Medical History:

- Infections: _____
- Behavior Problems: _____
- Surgeries: _____
- Hospitalization: _____
- Other: _____

Birth & Development:

- Full Term? ❑ Yes ❑ No
- Birth Weight: _____
- Delivery? ❑ Vaginal ❑ C-Section
- Birth Complications: _____
- Pregnancy issues (meds, alcohol, smoking)?

Family & Social History:

- Smoking exposure at home? ❑ Yes ❑ No
- Day Care? ❑ Yes ❑ No
- Siblings (how many)? _____
- Pets (what kind)? _____

Medications (taking any?) ❑ Yes ❑ No

- If yes – what? _____

Lead Exposure Risk:

- House built before 1960? ❑ Yes ❑ No
- Parents work with lead? ❑ Yes ❑ No

Allergies: ❑ None

❑ Medications: _____

❑ Environmental: _____

❑ Latex

Have you seen or consulted specialist or other health care providers? ❑ Yes ❑ No

If yes, please list: _____