Bayou Pediatric Associates

Medical History and Family History Form

Name _____ **DOB _____**

Birth History

Gestation Weeks _____
Vaginal or C-Section Delivery _____
Hospital of Delivery _____
Infant's Doctor _____
Birth Weight _____
Date of Discharge _____
Hearing Screening - Passed or Failed (Circle One)

Medical History

Recurrent Illnesses _____
Chronic Illnesses _____
Seizures _____
Recurrent Ear Infections _____
Recurrent Tonsilitis\Sinusitis_____
Diptheria/Mumps/Meales/Rubella _____
Eczema _____

Surgical History

Adenoid removal _____
Tonsil removal _____
Ear Tubes _____
Circumcision _____

Social History

Any smokers that live in the home? _____
Pets in the home? What type? _____
How many people live in the home? _____
Birth to school age childcare? Private Sitter/Stay home parent or Daycare (circle one)
School age children? Attends school /Homeschool/Not in school (circle one)
Tobacco use? (12 yrs and older)_____
Recreations Drug use? (12 yrs and older) _____
Alcohol Use (12 yrs and older) _____
Sexually Active (12 yrs and older) _____

Lead Poisoning Risk Assessment age 6 mths – 5 yrs)

Lives in or visits house built before 1960 _____
Lives in 1960 or earlier house being renovated _____
Family or Playmate with lead poison_____
Adult works with lead, pottery or ceramics _____
Livers near battery recycling plant or lead industry _____
Uses folk remedies that contain lead _____
Lives near highway or heavy traffic _____
Lives in house with lead pipes or shoulder joints _____

Family History –Applies to Parents, Grand Parents, Siblings, Aunts, Uncles and Cousins

Maternal History (Mother's Side)

Allergies _____
Arthritis _____
Asthma_____
Cancer _____
Diabetes _____
Elevated Cholesterol _____
Heart Disease _____
High Blood Pressure _____
Sickle Cell Disease _____
Thyroid Disease _____

Paternal History (Father's Side)

Allergies _____
Arthritis _____
Asthma _____
Cancer_____
Diabetes_____
Elevated Cholesterol _____
Heart Disease _____
High Blood Pressure _____
Sickle Cell Disease _____
Thyroid Disease _____

Any additional medical history, family history or concerns: _____

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