MEDICAL HISTORY

Child's Name: _____ DOB: _____

Medications: _____

Allergies (medications, foods, etc.): _____

Are child's immunizations up to date? yes ☐ no ☐

BIRTH HISTORY (only need to complete if child is less than 5 years old)

Hospital where child was born: _____

Birth weight: _____ Discharge weight: _____ vaginal ☐ C-section ☐

Gestational age (weeks old at birth): _____ Reason for C/S (if applicable): _____

Hep B given? yes ☐ no ☐ Hearing screen passed? yes ☐ no ☐

Mom's pregnancy health: _____

Complications with infant: _____

NICU? yes ☐ no ☐ _____

PAST MEDICAL HISTORY

Hospitalizations: _____

Surgeries: _____

ADHD/ADD	☐	Cancer (list type)	☐	Kidney Disease	☐
Allergies	☐	Cerebral Palsy	☐	Learning Disability	☐
Anemia	☐	Diabetes	☐	Migraines	☐
Asthma	☐	Eczema	☐	Seizures	☐
Autism	☐	Freq. Ear Infections	☐	Sickle Cell Disease	☐
Bronchiolitis	☐	Heart Defect	☐	Urinary Tract Infections	☐

Other: _____

MEDICAL HISTORY

FAMILY HISTORY (note F - father, M - mother, S - sibling, GF - grandfather, GM - grandmother)

ADHD/ADD _____	Depression _____	Migraines _____
Allergies _____	Diabetes _____	Seizures _____
Anemia _____ (not iron related)	Heart Attack _____ (list age of occurrence)	Sickle Cell Disease _____
Asthma _____	High Blood Pressure _____	Sickle Cell Trait _____
Autism _____	High Cholesterol _____	Stroke _____ (list age of occurrence)
Bleeding Disorder _____	Kidney Disease _____	Sudden Cardiac Death _____ (list age of occurrence)
Cancer (list type) _____	Mental Illness _____	Thyroid Disease _____

Other: _____

SOCIAL HISTORY

Household Members: _____

Who is primary caretaker(s) or has custody of child: _____

Childcare: Attends school/preschool ☐ Attends daycare ☐ Stays home ☐

Pets Yes ☐ No ☐

Smokers (including outside) Yes ☐ No ☐

Comments: _____

HOW DID YOU HEAR ABOUT COBB PEDIATRIC ASSOCIATES?

From a friend (word of mouth) ☐	Google ☐
Insurance Company ☐	Another doctor (OB/GYN) ☐
Facebook ☐	Other _____