LAURELWOOD pediatrics

Family Health History

♦Dr. Lana Yanishevski ♦ Dr. Chris Hanson ♦ Dr. Ashley Miller ♦ Dr. Joel Siegel ♦ Dr. Nouth Magdovitz

Please complete this page once for your entire family

Please list all household members:

NAME	DATE OF BIRTH

If mother and father are not living together, what is the child's/children's custody status?

_____

Family History – Please put a check in any of the boxes and explain further below

	Father	Mother	Father's Parents	Mother's Parents	Brother or Sister		Father	Mother	Father's Parents	Mother's Parents	Brother or Sister
Cancer						Kidney Disease					
Diabetes						Glaucoma					
Heart Disease						Bleeding Disorders					
Stroke						Mental Illness					
High Blood Pressure						High Cholesterol					
Immune Problems						Epilepsy/ Seizures					
Other:						Other:					

Please explain: _____

_____

_____

_____

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Initial Health Questionnaire

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Child's Name: _____ Date of Birth: _____

Who will be this child's primary pediatrician? _____

Birth History - Please explain any "Yes" answers below

- What was your child's birth weight? ____ pounds ____ ounces
- Was your child born prematurely? (more than 1 month early) □ Yes □ No
- Was your child born by C-section? □ Yes □ No
- Were there any pregnancy complications? □ Yes □ No
- During pregnancy, did the mother take any prescription medicines? □ Yes □ No
- During pregnancy, did the mother smoke, drink alcohol, or use drugs? □ Yes □ No

General History - Please explain any "Yes" answers below

- Do you have any concerns about your child's health, such as physical, mental or emotional development? □ Yes □ No
- Do you have any concerns about your child's attention span? □ Yes □ No
- Do you have any concerns about your child's performance in school? □ Yes □ No
- Does your child have any serious illnesses or medical conditions? □ Yes □ No
- Has your child had any serious injuries or accidents? □ Yes □ No
- Has your child ever had a surgery? □ Yes □ No
- Has your child ever been hospitalized? □ Yes □ No
- Has your child ever seen any specialists? □ Yes □ No
- Is your child allergic to any medications? □ Yes □ No

Please explain: _____

_____

_____

Child's Name: _____ Date of Birth: _____

Medical History- Please answer every question

	Yes	No	Please explain any "Yes" answers
Frequent ear infections?			
Problems with hearing?			
Nasal allergies?			
Asthma, bronchitis, bronchiolitis, or pneumonia?			
Any heart problem or murmur?			
Anemia or bleeding problem?			
Frequent abdominal pain?			
Constipation requiring doctor visits?			
Bladder or kidney infections?			
Bedwetting (after 5 years old)?			
Any chronic or recurrent skin problems (acne, eczema, etc.)?			
Frequent headaches?			
Head injury?			
Seizures or other neurological problems?			
Diabetes?			
Thyroid or endocrine problems?			
(Females only) Has she started her periods?			If yes, at what age was her first period? ____
(Females only) Any problems with her periods?			