Springdale-Mason
PEDIATRIC ASSOCIATES, INC.

Child's Name: _____ Date of Birth _____

Past Medical History

Pregnancy/Neonatal Period

Full Term: □ Yes □ No
Born at _____ weeks
Birth Weight: _____
Delivery: □ Vaginal □ C-Section
Reason for C-Section: _____
Any Birth Complications: _____

Infancy/Childhood/Adolescence

Has your child ever been treated for or diagnosed with (explain):

□ Asthma or Reactive Airway Disease _____
□ Wheezing or bronchiolitis _____
□ Pneumonia _____
□ Seasonal Allergies _____
□ Food Allergies _____
□ Eczema _____
□ Recurrent Ear Infections _____
□ Urinary tract infections _____
□ Genetic Syndrome _____
□ Seizures _____
□ Anemia _____
□ Broken Bone _____
□ Learning Disability _____
□ ADD/ADHD _____
□ Autism Spectrum Disorder _____
□ Developmental Delay _____
□ Depression/Anxiety _____

Other chronic medical conditions: _____
Has your child ever been hospitalized: □ Yes □ No (explain)
_____
Previous Surgeries and dates: _____
_____

Allergic to any medications: □ Yes □ No (explain)
_____
Current Medications and dose: _____
_____
Please list any specialist your child is currently seeing and reason: _____
_____

Social History

Child's parents are: □ Married □ Unmarried □ Divorced □ Other
Who lives in the household with child? □ Mom □ Dad □ Siblings (#_____)
□ Grandparents □ Other _____
Do any household members smoke? □ Yes □ No
Any Pets in the home? □ Yes □ No
What kind of pets: _____
Any guns in the home? □ Yes □ No
Are they locked up? □ Yes □ No