

**CARTERSVILLE PEDIATRICS
HISTORY**

<i>Delivery:</i>	<input type="checkbox"/> Vaginal	<input type="checkbox"/> C-Section	Weight: _____
	<input type="checkbox"/> Full Term	<input type="checkbox"/> Premature	Height: _____
Please list Mother's illnesses during pregnancy: _____ _____			
Medications taken during pregnancy (prescription & non-prescription): _____ _____			
Problems during delivery: _____ _____			
Did baby go home with mom? Yes _____ No _____ If no, why? _____ _____			
Were there any other problems in the first month after the birth? _____ _____			

<u>CHILD'S HISTORY:</u>	Is your child allergic to:
	<input type="checkbox"/> Drugs _____ <input type="checkbox"/> Insects _____
	<input type="checkbox"/> Food _____ <input type="checkbox"/> Shots _____
Please list your child's current medicines: _____ _____	
What illnesses or injuries has your child had? _____ _____	
Has your child ever been hospitalized or had surgery? (Please describe and list the child's age for each): _____ _____	
Is there anything your provider should know about your child's health? _____ _____	

<u>FAMILY HISTORY:</u>	Has anyone in your child's family had any of the following diseases?
	<input type="checkbox"/> Alcohol / Drug Use <input type="checkbox"/> Cancer
	<input type="checkbox"/> Asthma / Allergies <input type="checkbox"/> Diabetes
	<input type="checkbox"/> Behavioral Problems <input type="checkbox"/> Hearing / Vision Problems
	<input type="checkbox"/> Birth Defects <input type="checkbox"/> Heart Disease / High Blood Pressure
	<input type="checkbox"/> Blood disorders / Sickle Cell <input type="checkbox"/> Seizures / Epilepsy
	Other _____

Please Initial: _____

PATIENT'S NAME: _____
ACCOUNT #: _____
BIRTHDATE: _____

Office Location:

Cartersville Pediatric Associates at Cartersville
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