PEDIATRIC CARE CENTER
OPEN 24 HOURS, 7 DAYS A WEEK

JACKSONVILLE (904) 519-6555
8117 Point Meadows Drive • Jacksonville, FL 32256

JACKSONVILLE BEACH (904) 249-3373
274 Third Avenue South • Jacksonville Beach, FL 32250

24hourkidcare.com

MEDICAL HISTORY FORM

PATIENT FIRST NAME:	PATIENT LAST NAME;	PATIENT DATE OF BIRTH:
BIRTH HOSPITAL:	BIRTH WEIGHT:	BIRTH HOSPITAL:
_____ VAGINAL _____ C-SECTION	WEEKS GESTATION: _____	IS THE PATIENT A MULTIPLE (TWIN, TRIPLET ETC.) _____ YES _____ NO
IF C-SECTION, WHY?	DID THE PATIENT REQUIRE INTENSIVE CARE / NICU? _____ YES _____ NO	MOTHER'S OBSTETRICIAN NAME:

LIST ANY BIRTH COMPLICATIONS, DEFECTS OR ABNORMALITIES:

DID YOUR CHILD HAVE ANY OF THE FOLLOWING AT BIRTH:

- ☐ *JAUNDICE REQUIRING PHOTOTHERAPY*
- ☐ *RESPIRATORY DISTRESS REQUIRING OXYGEN/MECHANICAL VENTILATION*
- ☐ *FAILED NEWBORN HEARING SCREENING*
- ☐ *HEART MURMUR REQUIRING EVALUATION*
- *ABNORMAL ULTRASOUND*
- ☐ *FEVER/INFECTION*

LIST ANY KNOWN ALLERGIES AND TYPE OF REACTION

LIST ALL CURRENT MEDICATIONS:

LIST ALL PREVIOUS / DISCONTINUED MEDICATIONS:

PLEASE LIST ANY HOSPIITALIZATIONS / SURGERIES

DATE	HOSPITAL NAME/LOCATION	REASON
DATE	HOSPITAL NAME/LOCATION	REASON
DATE	HOSPITAL NAME/LOCATION	REASON

WERE THERE ANY NEGATIVE REACTIONS TO ANESTHESIA? _____ YES _____ NO

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MEDICAL HISTORY, cont.

LIST ANY OTHER PROVIDERS WHO SEE YOUR CHILD:

HAS YOUR CHILD HAD ANY OF THE FOLLOWING? (check all that apply)

- ☐ *ADHD*
- ☐ *ASTHMA*
- ☐ *BLOOD DISORDER*
- ☐ *DIABETES*
- ☐ *HEART MURMUR*
- ☐ *KIDNEY DISEASE*
- ☐ *RECURRENT EAR INFECTIONS*
- ☐ *RECURRENT INFECTION*
- ☐ *RECURRENT U.T.I*
- ☐ *SEIZURES*
- ☐ *SICKLE CELL ANEMIA*
- ☐ *TRAUMA/ACCIDENT*

PLEASE EXPLAIN ANY ITEM CHECKED ABOVE OR OTHER HISTORY OUR PROVIDER'S SHOULD BE AWARE OF:

CHECK ANY THAT APPLY TO YOUR CHILD:

- ☐ *BOTTLE FED until what age?*_____
- ☐ *BREASTFED until what age?*_____
- ☐ ***PACIFIER USE*** *until what age?*_____
- ☐ *DOES YOUR CHILD ATTEND DAYCAR?* _____ *YES* _____ *NO*

PLEASE LIST WHO LIVES IN THE HOUSEHOLD:

DOES ANY HOUSEHOLD MEMBER OR CARETAKER SMOKE? _____ **YES** _____ **NO**

HAS ANYONE IN YOUR FAMILY EVER BEEN DIAGNOSED WITH THE FOLLOWING? (Circle and indicate relationship)

- ☐ *ASTHMA*
- ☐ *ALLERGIC RHINITIS*
- ☐ *CANCER*
- ☐ *DEPRESSION*
- ☐ *DIABETES*
- ☐ *GALLSTONES*
- ☐ *HEART DISEASE*
- ☐ *HEPATITIS*
- ☐ *HIGH CHOLESTEROL*
- ☐ *HIGH BLOOD PRESSURE*
- ☐ *INFLAMMATORY BOWEL DISEASE*
- ☐ *KIDNEY DISEASE*
- ☐ *KIDNEY STONES*
- ☐ *MENTAL ILLNESS*
- ☐ *MIGRAINE HEADACHES*
- ☐ *SICKLE CELL ANEMIA*
- ☐ *OTHER ANEMIA*
- ☐ *STROKE*
- ☐ *THYROID DISEASE*
- ☐ *ULCERS*