PediatriCare of Northern VA, P.C. (703) 330-3939
8640 Sudley Rd, Suite 306, Manassas, VA 20110 *15195 Heathcote Blvd, Suite 250, Haymarket, VA 20169*

Patient Medical History

Patient Name:_____ DOB:_____

Pregnancy & Birth	**Mother's Age at child's Birth?**
Any problems during pregnancy? ☐ Excessive Weight Gain ☐ Excessive Swelling ☐ UTI ☐ Toxemia ☐ Venereal Disease ☐ Other (Please Explain)	
Medication during Pregnancy? ☐ Yes ☐ No Exclude Vitamins & Iron	
During pregnancy did Mom ☐ Smoke ☐ Drink Alcohol ☐ Do street Drugs	
At Birth, how many gestational weeks was your child? (e.g. term = 40 weeks)	
Type of Delivery? ☐ Vaginal ☐ Cesarean Section Birth Weight Length	
Problems with baby at birth? Breathing: ☐ Yes ☐ No **Jaundice:** ☐ Yes ☐ No	
Problems soon after Birth?	
Feeding: ☐ Breast Milk ☐ Formula Type of Formula:	
Feeding Problems? ☐ Colic ☐ Recurrent Vomiting ☐ Recurrent Diarrhea ☐ Multiple Formula Changes	

Past Medical History	**Allergic Reactions?** **Medicine**: ☐ Yes ☐ No **Food:** ☐ Yes ☐ No
Animals: ☐ Yes ☐ No **Insect Bites:** ☐ Yes ☐ No **Please List**	
Medications taken on a regular basis? (excludes vitamins)	
Hospitalizations – (when-where-why)	
Serious Injuries – (when-where)	

Past, Present & Recurrent Illnesses

	Yes	No		Yes	No
Measles	☐	☐	Mumps	☐	☐
Chicken Pox	☐	☐	Whooping Cough	☐	☐
Scarlet Fever	☐	☐	Ear Infections	☐	☐
Asthma/Wheezing	☐	☐	Eczema/Hives	☐	☐
Anemia	☐	☐	Hepatitis	☐	☐
Bleeding Tendency	☐	☐	Urinary Infections	☐	☐
Blood Transfusions	☐	☐	Joint Problems	☐	☐
German Measles	☐	☐	Problems Hearing	☐	☐
Seizures	☐	☐	Problems w/vision	☐	☐
Strep Throat	☐	☐	Other	☐	☐

Family Medical History	**List all blood relatives of your child who have had the following problems – use abbrev. (F) Father, (M) Mother, (B) Brother, (S) Sister, (MM) Mother's Mother, (MF) Mother's Father, (FM) Father's Mother, (FF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin**			
Anemia/Blood Disorders	Allergies	Alcoholism	Arthritis	Aids/HIV
Asthma	Allergy Shots	Cancer	Cystic Fibrosis	Cholesterol Problems
Birth Defects	Diabetes	Eczema	Ear Tubes	Epilepsy/Seizures
Drug Problem	Early Deafness	Emotional/Behavioral Problems	Growth Problems	Heart Attack/Stroke
Heart Disease	High Blood Pressure	Hereditary Problems	Intellectually Challenged	Muscular Dystrophy
Migraines	Tuberculosis	School Problems	Sudden Infant Death	Other

Signed _____ **Date**_____