TLC Pediatrics
"TLC for your kids."

MEDICAL HISTORY

Patient's Name _____ Date of Birth: _____

Legal Sex: Male Female Other Gender (if different from legal sex): _____

Birth Hospital_____

Birth Weight_____

Pregnancy Complications if applicable_____

Delivery Complications if applicable_____

Allergies if applicable_____

Surgeries or Hospitalizations:_____

Any other concerns we should be aware of?

_____

_____

Family History - Circle any medical conditions that run in your immediate family

anemia, alcoholism, asthma, allergies, cancer, diabetes, heart trouble, high blood pressure, high cholesterol, inherited illness, mental illness, seizures, substance abuse, tuberculosis

List any others:_____

Social History -

Are you concerned about your child's behavior or development?

O No O Yes

Does your child have trouble in school? (if applicable)

If yes, explain _____

Does your child use a seat belt or car seat?	O No	O Yes
Does your child use a bicycle helmet?	O No	O Yes
Is there a swimming pool?	O No	O Yes
Does anyone smoke at home or regularly expose child to tobacco smoke?	O No	O Yes
Are there any pets in the house?	O No	O Yes
Do you have a record of your child's immunizations?	O No	O Yes
Are your child's immunizations UTD?	O No	O Yes

Is your child currently in good health?

If yes, explain _____

Do you have any concerns about your child?

If yes, explain _____