LAKE COUNTRY PEDIATRICS S.C. PATIENT HISTORY FORM

History of Pregnancy and Delivery of Patient

Complications: ____NO ____Yes explain):_____
Birth Weight: _____ Apgar score(s):_____
Breast or Formula Fed (if formula, which brand?): _____

Family Member/Home Information

Mother: _____ Date of Birth: ____/____/____
Father: _____ Date of Birth: ____/____/____
Siblings: _____
Number of Pets: _____ Type(s):_____
Smoking: ____No ____Yes: In Home / Outside (please circle all that apply)
Fireplace: ____No ____Yes: Natural / Gas (please circle all that apply)
Smoke Detector(s): ____No ____Yes
Carbon Monoxide Detector(s): ____No ____Yes

Drug or Food Allergies

(Please list all that apply)

_____
_____
_____
_____

Surgical History

Reason Date

_____
_____
_____
_____

Patient Medication(s)

_____
_____
_____
_____

Hospitalization(s)

Reason Date

_____
_____
_____

Medical History for Family and Patient (place "x" next to all that apply)

Please, write under "status" whether family member is alive or deceased.

Person	Asthma	seasonal allergies	Eczema	Skin Problems	Gerd/Reflux	ADHD	Depression	Drug/Alcohol abuse	Anxiety	Hypertension	Heart Disease	Heart Attack (<60yo)	Stroke	High Cholesterol	Diabetes	Siezures/Epilepsy	Cancer	Kidney Problems	Bladder Problems	Thyroid Disease	AutoimmuneDisease	Arthritis
Patient																						
Mother																						
Father																						
Sister																						
Brother																						
MGM																						
MGF																						
Mat Aunt																						
Mat Uncle																						
PGM																						
PGF																						
Pat Aunt																						
Pat Uncle																						