The Children's Medical Group
104 Fulton Avenue
Poughkeepsie, NY 12603

YOUR CHILD'S MEDICAL HISTORY

In order for us to know your child better, please answer all the questions below.

Date: ______ Child's Name ____________________ Date of Birth: __________ Birth Weight: ________

Yes	No	
___	___	1. Was your pregancy less than 37 or more than 41 weeks? If so, how long was it? ______ weeks
___	___	2. Were there any problems with your pregnancy? (e.g. hospitalization, infection, early labor) If yes, please explain ______
		3. Was your delivery Vaginal________ Forceps________ Vacuum________ Cesarian ________
___	___	4. Any problems with your delivery? If yes, please explain ______
___	___	5. Did your baby have any problems in the nursery? (e.g. fever, breathing problems, NICU stay) If yes, please explain ______
___	___	6. Has your child had any problems with growth or development? If yes, please explain ______
___	___	7. Has your child ever been hospitalized overnight? If yes, please explain ______
___	___	8. Has your child ever had any operations or surgery? If yes, please explain ______
___	___	9. Has your child ever had any blood transfusions?
___	___	10. Has your child had any serious infections? (e.g. pneumonia, meningitis, urine infection, Lyme, etc) If yes, please explain ______
___	___	11. Has your child had any other type of serious illness? (medical or traumatic) If yes, please explain ______
___	___	12. Does your child have any chronic illnesses? (e.g. asthma, heart problems, arthiritis, sickle cell, etc.) If yes, please explain ______
___	___	13. Does your child have any recurring illness? (e.g. bronchitis, ear or bladder infections, etc.) If yes, please explain ______
___	___	14. Is your child allergic to any medications, foods, animals, or other things? If yes, please explain ______
___	___	15. Does your child take medication for any problem? (other than pain relievers and cold remedies) If yes, please explain ______
		16. Has your child had any problems with: (If yes, please explain.)
___	___	Head, Eyes, Ears, Nose, Throat______
___	___	Heart______
___	___	Lungs______
___	___	Stomach or Bowel______
___	___	Kidney or Bladder______
___	___	Muscles, Nerves or Brain______
___	___	Hip Disorders______
___	___	Excessive Bleeding______
___	___	Hearing or Vision______
___	___	School Problems______
___	___	Emotional or Behavioral Problems______

(Please Complete Other Side)

The Children's Medical Group
104 Fulton Avenue
Poughkeepsie, NY 12603

Yes	No	
		17. Does the child's mother or father or anyone in their immediate family have a history of:
____	____	Genetic or Inherited illnesses________________
____	____	Diabetes Adult Type________________
____	____	Diabetes Child Type________________
____	____	Asthma________________
____	____	Hay Fever________________
____	____	Eczema________________
____	____	Heart Attack________________
____	____	High Blood Pressure________________
____	____	Heart Disease________________
____	____	Seizures or Epilepsy________________
____	____	Cancer________________
____	____	High Cholesterol________________
____	____	Kidney Problems________________
____	____	Alcoholism or Substance Abuse________________
____	____	Psychiatric Illness (e.g. Bipolar, Depression, Schizophrenia)________________
____	____	Any other serious illness________________
____	____	18. Does anyone living in your household smoke cigarettes?
____	____	19. Does anyone living in your household have a problem with alcohol or drugs?
____	____	20. Has your child had chickenpox disease (date: ____________)?
____	____	21. Is Flouride missing from your drinking water?

(City & Town of Poughkeepsie & Newburgh have Flouride;Ulster Couty does not & Well water does not)

22. What is the current marital status of parents?

Married ____ Single ____ Separated ____Divorced ____ Re-Married _____Widowed_____

23. Who currently lives in your home?________________________________

____

24. Father's Occupation ________________________________

Mother's Occupation ________________________________

25. Please list names and birthdates of siblings:

Name	**Birthdate**

Please explain any other medical history that you consider important:

____
____
____
____
____

REVIEWED BY CMG PROVIDER:

SIG: ________________________ **DATE:**____________

7/18/08MP