## PENN STATE HEALTH MEDICAL GROUP – ALL ABOUT CHILDREN

**Medical History** of (child's name)_____
Birth date:_____

Please Complete this so that we may know how to best serve you, your family, and your child.

I. Birth History:
Mother's History During pregnancy: Blood Type _____ Age at Delivery _____
Number of Pregnancies _____ Number of live births _____
Baby: Type of Delivery (circle one): Vaginal / C-Section On time/ Premature
Weeks Gestation_____ Length _____inches Weight _____lbs _____oz
Problems after birth: None/ Yes: (please describe)

II. Please list all operations, hospitalizations, concussions, fainting spells, broken bones

_____

_____

_____

III. If your child has ever had any of the following, please circle it:

| | | | |
|---|---|---|---|
| AIDS or HIV | Anemia | Arthritis | Asthma |
| Bladder Infection | Cancer | Chickenpox | Depression |
| Diabetes | Eczema | Epilepsy/Seizures | Hearing Problems |
| Heart Disease | Hepatitis | Hernia | High Blood Pressure |
| Inherited disease | Kidney Disease | Lead Poisoning | Leukemia |
| Lung Disease | Measles | Mental Illness | Mononucleosis |
| Mumps | Pneumonia | Rheumatic Fever | Scarlet Fever |
| Stroke | Thyroid Disease | Tuberculosis | Weight Problems |
| Whooping Cough | Other:_____ | | None |

IV. List Allergies:

_____

_____

V. List Medications:

_____

_____

Completed by: _____ Date: _____

Relation to Child: _____