Bluegrass Pediatrics & Internal Medicine, PLLC

Past and Current Medical History

Have you (the patient) been diagnosed with any of the following? Check all that apply.

Cancer:		Heart		Renal		Other: (List)
	Breast □		Heart Disease/Heart Attack □		Kidney Disease □	
	Lung □		Congestive Heart Failure □		Renal Failure □	
	Skin □		Peripheral Vascular Disease □		Urine Leakage □	
	Throat □		Angina/Chest Pain □	Bone		
	Prostate □		High Blood Pressure □		Osteoporosis □	
Mental Health					Recent Fractures □	
	Anxiety □	Blood			Fibromyalgia □	
	Depression □		Blood Clots/DVT □		Osteoarthritis □	
	Memory Problems □		Anemia □		Lupus □	
	Bipolar Disorder □		Hemophilia □		Rheumatoid arthritis □	
	ADHD □		Bleeding Problems □	Breathing		
		GI			Athma □	
Brain			Nausea/Vomiting □		Breathing Difficultries □	
	Migraine/Headache □		GERD/Reflux □		COPD □	
	Hearing Loss □		Special Diet Needs □		Black Lung □	
	Stroke/CVA □		Stomach Ulcer □	Endo		
	Seizures □		Hernia □		Diabetes □	
	Sleep Apnea □		IBS □		High/Low Thyroid □	
	Dizziness □		Liver Disease □	Skin		
	Fainting □		IBD □		Eczema □	
	Ringing in ears □				Acne □	

For Pediatric Patients only

Immunizations up-to-date? □ Yes □ NO If Yes, where: Office Name:_____

City_____ State_____ Zip _____

Phone Number _____ Fax _____

Concerns for growth and development? □ Yes □ No If Yes, please specify _____

Please Check all that apply:

Chicken pox	□	Fractures	□	Overactive	□
Measles (Rubeola)	□	Operations	□	Impulsive	□
Rubella	□	Contusions	□	Lacking in self control	□
Meningitis	□	Anemia	□	Problems with:(**check all that apply**)	
Convulsions	□	iron deficienc	□	Peers	□
Blood Transfusions	□	Sickle Cell	□	Siblings	□
Poison Ingestion	□	Mumps	□	Parents	□
Bed wetting	□			Sleep	□
				Attention	□
				School	□
				Mood	□

Any other concerns you would like to discuss today? _____

Other serious medical issues:

Social History

Tobacco Use: □ Current □ Past □ Never If **Yes, how much:** _____ packs per day □ Quit : Year _____
Alcohol: □ **NO** □ YES : How much? _____ Drinks per week
Recreational

Occupation _____ □ Retired □ Disabled □ Student □ Minor

Home Living Situation (Check all that apply)

□ Alone □ With mother □ With father □ With spouse □ With siblings □ With children □ In nursing home □ In assisted living □ In foster care □ With significant other □ other

Family History: Check which family members have had the following:

	None	Mother	Father	Sister	Brother	Other
Heart Disease	□	□	□	□	□	□
Cancer	□	□	□	□	□	□
Thyroid Disease	□	□	□	□	□	□
High Blood Pressure	□	□	□	□	□	□
Asthma	□	□	□	□	□	□
Stroke	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□
Kidney Problems	□	□	□	□	□	□
Bleeding Problems	□	□	□	□	□	□
Clotting Problems	□	□	□	□	□	□

Allegries : Are you allergic to any of the following? Check all that apply. □ **NONE**

	Name of medication	What happens when you take this medication?
1		□ Itching □ Rash □ Nausea □ Shortness of Breath □ Anaphylaxis □ Other _____
2		□ Itching □ Rash □ Nausea □ Shortness of Breath □ Anaphylaxis □ Other _____
3		□ Itching □ Rash □ Nausea □ Shortness of Breath □ Anaphylaxis □ Other _____
4		□ Itching □ Rash □ Nausea □ Shortness of Breath □ Anaphylaxis □ Other _____
5		□ Itching □ Rash □ Nausea □ Shortness of Breath □ Anaphylaxis □ Other _____
6		□ Itching □ Rash □ Nausea □ Shortness of Breath □ Anaphylaxis □ Other _____

Current Medications: □ **NONE**

	Name of medication	Strength (mg)	How many times a day?	Reason for taking
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Past surgical History: (Include all operations that you have had)

	Name of operations	Date	Reason	Hospital	Surgeon
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

This form was completed by _____ Date _____
Relationship to patient □ Self □ Mother □ Father □ Daughter □ Son □ Other (specify) _____