Pediatric Center of Round Rock, P.A. dba River Ridge Pediatrics
1526 Leander Rd, Georgetown, TX 78628

Patient Name:_____
DOB:_____ Date:_____
☐ Male ☐ Female

Medical History Information Provided by:_____

Reason for visit:_____

Current Medications:_____

Allergies to medications?_____ _____ Foods?_____ Other?_____

Past Medical History (Any diseases or problems with any of the following? Check box if yes and explain)

☐ Eyes:_____ ☐ Heart:_____ ☐ Muscle:_____

☐ Ears:_____ ☐ Stomach or Intestines:_____ ☐ Bone Problems:_____

☐ Nose:_____ ☐ Kidneys:_____ ☐ Skin:_____

☐ Throat:_____ ☐ Lungs (i.e. asthma):_____ ☐ Endocrine:_____

☐ Neurological: _____ ☐ Genetic disorder: _____ ☐ Other: _____

☐ Psychiatric disorder: _____ ☐ Developmental disorder: _____

Past Hospitalizations/Major Procedures/Serious Injuries (i.e. fractures, please note date/age) ☐ None

_____

Surgeries (Please note date/age) ☐ None

_____

Birth History Adopted: ☐ Yes ☐ No

Mother's Pregnancy History: ☐ Uncomplicated ☐ Complications:_____
(i.e. bleeding, infections, drug exposure, preterm labor)

Baby born: ☐ Term ☐ Preterm:_____weeks Feeding: ☐ Breast ☐ Formula ☐ Both

Delivery History Hospital:_____ City, State:_____ Birth Weight:_____

☐ Forceps Used ☐ Vaginal Delivery ☐ Cesarean Section/Reason:_____

Did baby have problems with: Breathing: ☐ Yes ☐ No Baby given oxygen: ☐ Yes ☐ No

Jaundice: ☐ Yes ☐ No Required Phototherapy: ☐ Yes ☐ No

Other Problems after delivery: _____

Immunizations Is your child immunized? ☐ Yes ☐ No Copy of record provided today? ☐ Yes ☐ No

Girls Have menstrual periods begun? ☐ Yes ☐ No At what age? _____

Environmental History

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Patient Name:_____
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Do any family members smoke? ☐ Yes ☐ No Contact with animals? ☐ Yes ☐ No Type:_____

Social History Child lives with: _____

Father's Occupation: _____ Mother's Occupation:_____

Are parents: Single_____ Married_____ Divorced _____ Remarried_____ Deceased_____

Family History Father's Age: ____ Mother's Age:____ Brother's Age(s):_____ Sister's Age(s):_____

Do any relatives (parents, siblings, aunts, uncles, grandparents) have any of the following diseases?

		Relation to Patient	**Maternal/Paternal**
Deafness	☐ Yes ☐ No	_____	_____
Eye Disease	☐ Yes ☐ No	_____	_____
Tuberculosis	☐ Yes ☐ No	_____	_____
Asthma	☐ Yes ☐ No	_____	_____
Diabetes	☐ Yes ☐ No	_____	_____
Endocrine (hormone)/Thyroid	☐ Yes ☐ No	_____	_____
Anemia/Bleeding disorder	☐ Yes ☐ No	_____	_____
Gastrointestinal disorder	☐ Yes ☐ No	_____	_____
Kidney Disease	☐ Yes ☐ No	_____	_____
Heart Disease/Stroke	☐ Yes ☐ No	_____	_____
High Blood Pressure	☐ Yes ☐ No	_____	_____
High Cholesterol	☐ Yes ☐ No	_____	_____
Muscle or Bone disease	☐ Yes ☐ No	_____	_____
Seizures	☐ Yes ☐ No	_____	_____
Developmental delay	☐ Yes ☐ No	_____	_____
Birth Defects	☐ Yes ☐ No	_____	_____
Chromosome disorder	☐ Yes ☐ No	_____	_____
Cancer	☐ Yes ☐ No	_____	_____
Psychiatric	☐ Yes ☐ No	_____	_____

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