Small World Pediatrics, P.A.

2527 Windguard Circle, Ste 102, Wesley Chapel, FL 33544
Phone (813) 907-8001 • Fax (813) 907-5744

PAST MEDICAL HISTORY
PAGE 1 OF 2

Patient Name: _____ Date of Birth: _____ /_____ /_____

Previous Physician: _____

_____
Address

_____ _____ _____
City State Zip

Phone: _____

Specialists: _____ _____
_____ _____

<u>Patient</u> Medical History:
Surgeries: _____ Year: _____
Medical Allergies: _____
Other Allergies: _____
Vaccine reactions: _____

Allergies:	Y N	Tuberculosis:	Y N	Genetic Disease:	Y N
Asthma:	Y N	Hepatitis:	Y N	Sickle Cell Anemia:	Y N
Eczema:	Y N	Cirrhosis:	Y N	Autism Spectrum Disorder:	Y N
Emphysema:	Y N	Ulcerative Colitis:	Y N	PDD:	Y N
Cystic Fibrosis:	Y N	Crohn's disease:	Y N	ADD:	Y N
Congenital Heart Disease:	Y N	Arthritis:	Y N	ADHD:	Y N
Hypertension:	Y N	Neurological Disorder:	Y N	Birth Defects:	Y N
High Cholesterol:	Y N	Seizure Disorder:	Y N	Immunodeficiency:	Y N
Diabetes:	Y N	Stroke:	Y N	HIV Infection:	Y N
Cancer:	Y N	Mental Illness:	Y N	Substance Abuse:	Y N
Thyroid Disease:	Y N	Learning Delay:	Y N	Prematurity: _____ weeks	Y N
Kidney Disease:	Y N	Speech Delay:	Y N		
Bleeding Problems:	Y N	Hearing Loss:	Y N		

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Patient Social History:

Please Circle One:
Home Care / Babysitter / Daycare / School
Parents Married / Divorced / Separated / Single
Shared Custody / Sole Custody
Smoker / Non-smoker

School Grade: _____
Extracurricular Activities: _____
_____

Please note, these questions are regarding the patient (all ages), not the family:

Alcohol Use:	Y N
Drug Use:	Y N
Caffeine Use (coffee, soda):	Y N
Exercise Habits Use:	Y N
Sexually Active:	Y N
Contraception (current):	Y N
Last Menstrual Cycle: __/__/__	Y N

Patient Family Medical History:

Allergies:	Y N	Tuberculosis:	Y N	Genetic Disease:	Y N
Asthma:	Y N	Hepatitis:	Y N	Sickle Cell Anemia:	Y N
Eczema:	Y N	Cirrhosis:	Y N	Autism Spectrum Disorder:	Y N
Emphysema:	Y N	Ulcerative Colitis:	Y N	PDD:	Y N
Cystic Fibrosis:	Y N	Crohn's disease:	Y N	ADD:	Y N
Heart Disease:	Y N	Arthritis:	Y N	ADHD:	Y N
Congenital Heart Disease:	Y N	Neurological Disorder:	Y N	Birth Defects:	Y N
Hypertension:	Y N	Seizure Disorder:	Y N	SIDS:	Y N
High Cholesterol:	Y N	Stroke:	Y N	Early Sudden Death:	Y N
Diabetes:	Y N	Mental Illness:	Y N	Immunodeficiency:	Y N
Cancer:	Y N	Learning Delay:	Y N	HIV Infection:	Y N
Thyroid Disease:	Y N	Speech Delay:	Y N	Substance Abuse:	Y N
Kidney Disease:	Y N	Hearing Loss:	Y N	Bleeding Problems:	Y N

I, as legal guardian verify that the above information is correct, and I authorize all Medical treatment/ procedures as may be deemed necessary for proper medical treatment.

_____ _____ _____ /_____ /_____
Signature **Print Name** **Date**

Patient Name: _____