MPPA Health History

Patient Name: ____________________

Date of birth: ____________________

☐Female ☐Male

Date: ____________________

A. Child's Birth History

Illnesses during pregnancy? [Y] [N] ____________________

Medications taken during pregnancy? [Y] [N] ____________________

Where was your baby born? ____________________

Was your baby born ☐early (< 37 weeks) ☐term ☐late (> 42 weeks)?

Delivery: ☐ Vaginal **Birth Weight**: _____ lbs _____ oz

☐ Breech **Birth Length**: ______inches

☐ C-Section Age at discharge from hospital:______

Complications during hospitalization: [Y] [N] ____________________

Was your baby:

Jaundiced: [Y] [N] how long? __________

Breast fed: [Y] [N] how long? __________

Formula fed: [Y] [N] how long? __________

Which formula? ____________________

B. Child's Past Medical History

1. Hospitalizations/Major Illnesses or Major Injuries/Surgeries

Year	Major Illness/Injury/Surgery	Hospital if required

2. Illnesses

Has your child ever had the following?

- Chicken pox.. [Y] [N] [?]
- Asthma/wheezing................................ [Y] [N] [?]
- Anemia... [Y] [N] [?]
- Bleeding tendencies............................ [Y] [N] [?]
- Blood transfusions.............................. [Y] [N] [?]
- Whooping cough................................. [Y] [N] [?]
- Recurrent ear infections (> 3)........... [Y] [N] [?]
- Pneumonia.. [Y] [N] [?]
- Eczema... [Y] [N] [?]
- Hepatitis... [Y] [N] [?]
- Seizures/Epilepsy................................ [Y] [N] [?]
- Allergies.. [Y] [N] [?]
- Congenital Heart Disease.................... [Y] [N] [?]
- Heart Murmur...................................... [Y] [N] [?]
- Problems with hearing......................... [Y] [N] [?]
- Problems with vision........................... [Y] [N] [?]

Describe: ____________________

Does your child have allergic reactions to: Medicines [Y] [N] Foods [Y] [N]

Other [Y] [N] Describe: ____________________

Does your child take any daily or seasonal medications? [Y] [N] Describe:

Are your child's vaccinations up to date? [Y] [N] [?]

C. Developmental History

Milestones	Age Achieved
Rolled over	
Sat alone	
Crawled	
Stood alone	
Walked	
Spoke first words	
Used sentences	
Toilet trained	
Dressed alone	
Grade in school	

Health History Continued

D. Family History

Relation	Age	Health Condition
Father		
Mother		
Brothers		
Sisters		

Have any of your child's blood relatives had any of the following conditions?

Medical Condition		Relation to child
AIDS	Y N ?	
Arthritis, gout	Y N ?	
Asthma	Y N ?	
Birth defects	Y N ?	
Bleeding disorders	Y N ?	
Cancer	Y N ?	
Cystic fibrosis	Y N ?	
Diabetes	Y N ?	
Epilepsy/seizures	Y N ?	
Heart Disease	Y N ?	
Hepatitis	Y N ?	
Hypertension	Y N ?	
Kidney Disease	Y N ?	
Mental Illness	Y N ?	
Muscular dystrophy	Y N ?	
Obesity	Y N ?	
Tuberculosis	Y N ?	
Other	Y N ?	

E. Social History

Are there any cigarette smokers in the home?	Y N	
Are there any pets in the home?	Y N	Please list: ____________ ____________
How many people live in the home?	1 2 3 4 5 6 7 8	Please list: ____________ ____________ ____________
Does your child attend day care?	Y N	Describe: ____________ ____________

F. Additional Information

Signature: ______________________________

Relation to patient: ______________________________