



**PIEDMONT PEDIATRICS, PLC**  
 20 Rock Pointe Lane  
 Warrenton, VA 20186  
 (540) 347-9900

**FAMILY HISTORY**

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: Male [ ] Female [ ]

Father's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Child's Previous Physician: \_\_\_\_\_

Hospital Where Delivered: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Gestational Age: \_\_\_\_\_ Vaginal [ ] C-Section [ ]

Were there any problems during pregnancy, labor or delivery? No [ ] Yes [ ]

If yes, please explain: \_\_\_\_\_

Baby's Feeding: Breast [ ] Formula [ ] - name of formula: \_\_\_\_\_

**Has your child ever experienced any of the following?** Please circle No or Yes. If Yes, please explain.

- |  |    |     |  |
|--|----|-----|--|
| Hospitalization                              | No | Yes | _____  |
| Surgery                                      | No | Yes | _____  |
| Fracture                                     | No | Yes | _____  |
| Bronchitis/Asthma                            | No | Yes | _____  |
| Hay Fever/ Allergies                         | No | Yes | (include food, medications, environmental, etc)<br>_____ |
| Eczema                                       | No | Yes | _____  |
| Other chronic or significant past illnesses: |    |     | _____<br>_____   |

**Family Medical History:** (please include child's immediate family - parents, brothers/sisters, grandparents)  
 Please circle No or Yes. If Yes, please explain.

- |                       |    |     |       |
|-----------------------|----|-----|-------|
| Heart Disease/Stroke  | No | Yes | _____ |
| Tuberculosis          | No | Yes | _____ |
| Epilepsy/Seizures     | No | Yes | _____ |
| Eye/Ear Problems      | No | Yes | _____ |
| Mental Retardation    | No | Yes | _____ |
| Chest/Lung Problems   | No | Yes | _____ |
| Stomach, Ulcers       | No | Yes | _____ |
| Kidney/Bladder        | No | Yes | _____ |
| Arthritis, Bone/Joint | No | Yes | _____ |
| Skin Problems         | No | Yes | _____ |
| Diabetes              | No | Yes | _____ |
| Allergies/Asthma      | No | Yes | _____ |
| Cancer                | No | Yes | _____ |
| High Blood Pressure   | No | Yes | _____ |
| High Cholesterol      | No | Yes | _____ |
| Alcoholism            | No | Yes | _____ |
| Mental Illness        | No | Yes | _____ |
| AIDS/HIV              | No | Yes | _____ |