Children's Hospital
Greenville Health System
New Impact

Medical History Form

All information will be kept confidential

Name of Patient:_____ DOB:_____

Address:_____

Home Phone #:_____ Work #:_____

Social History:

Who is living at home?	Mother / Step-Mother / Father / Step-Father / Siblings
Who prepares family meals?	Mother / Father / Self / Sibling / Grandparent
Which grocery store is the shopping done at?	Bi-Lo / Wal-Mart / Bloom / Publix / Other
What school does the child attend?	_____
What grade is the child in?	_____
How is the child doing in school?	Good / Fair / Poor

Family History:

Type 2 Diabetes	Siblings / Mother / Father / Grandparents / Aunts / Uncles
Gestational Diabetes	Yes / No
Thyroid Disease	Siblings / Mother / Father / Grandparents / Aunts / Uncles
Gallbladder Disease	Siblings / Mother / Father / Grandparents / Aunts / Uncles
Weight Issues	Siblings / Mother / Father / Grandparents / Aunts / Uncles

High Blood Pressure	Siblings / Mother / Father / Grandparents / Aunts / Uncles
High Cholesterol	Siblings / Mother / Father / Grandparents / Aunts / Uncles
Heart Disease	Siblings / Mother / Father / Grandparents / Aunts / Uncles
Stroke	Siblings / Mother / Father / Grandparents / Aunts / Uncles

Please specify:_____

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Please indicate your Pharmacy Information:

Name:_____ Phone #:_____

Address:_____