PEDIATRIC MEDICAL HISTORY FORM

Patient Name: ______________________ DOB: ______/______/_______

Parent/Guardian Signature: _________________ Date: _____/______/________

Present Health Concerns: ____

MEDICATIONS: *Please list all prescription and non-prescription medications, vitamins, home remedies, birth control, herbs etc.*

Medication Name	Dose	Frequency

ALLERGIES: *List all reactions to medicines, foods and other agents.*

Allergy	Reaction or Side Affect

***** If you are on 3 or more medications – please bring them with you to each appointment. *****

PERSONAL MEDICAL HISTORY: *Please indicate whether the patient has had any of the following medical problems.*

Asthma
Anemia
Pneumonia
Diarrhea
Hearing Problems
Heart Disease
Ear Infections
Convulsions/Epilepsy
Constipation
Rheumatic Fever
Vision Problems
Hay Fever
Other:________________________________
____
____

HOSPITALIZATONS: *Please list all prior hospitalizations and dates.*

Reason	Date

IMMUNIZATIONS: *Please list immunizations that the patient has received at other health care facilities and include your best estimate of the month and year of each immunization.*

Hepatitis A: _________ Measles: ___________ Mumps: ____________ Rubella: ____________ MMR: ______________
Hepatitis B: _________ Pneumovax: ________ Tdap: ______________ Varicella: ___________ Other: _____________

COMMUNICABLE DISEASES:

Has the patient ever had any of the following communicable disease(s)?

Chickenpox Measles Mumps Rubella Meningitis Tuberculosis (TB)

PREGNANCY & BIRTH:

Is the patient yours by: □Birth □Adoption □Stepchild □Other: ____

Were there any medical problems during pregnancy? □ Yes □ No If yes, please explain: ____

Were there are problems during labor and delivery? □ Yes □ No If yes, please explain: ____

Were there any problems such as needing oxygen, trouble breathing, jaundice (yellowness), etc. after the patient's birth? □ Yes □ No
If yes, please explain: ____

Where was the patient born? __________________________________ Method of Delivery: □Vaginal □ Caesarean

Birth Weight/Length: ___lbs. ___oz. ___inches Was your child born prematurely? □ Yes □ No If yes how early: __________________

For Male Patients Only: Is your child circumcised? □ Yes □ No

SLEEP:

How many hours a night does the patient sleep? ______ How many naps does the patient take per day and length of naps? _________

Does the patient have any sleep problems? □ Yes □ No If yes, please explain: ____

NUTRITION & FEEDING:

Type of feeding when the patient was a newborn: □Breastfed □Formula. If breastfed, for how long? ______________________________

Has the patient had any feeding/dietary problems or restrictions? □ Yes □ No If yes, please explain: ______________________________

____

Milk intake now: □ Soy Milk □ Rice Milk □ Cow's Milk (____ %) □ other, please specify: ___________, # of ounces per day ____________

Has the patient seen a dentist? □ Yes □ No If yes, date of last visit ________. What is the water source at the house? □ City □ Well

DEVELOPMENT:

At what age did the patient: Sit Alone _____ Walk Alone _____ Say Words _____ Toilet Train (Daytime) _____

Were there any concerns about growth or progress made in such areas as rolling over, walking, riding a tricycle, dressing themself, or feeding themself? □ Yes □ No If yes, please explain: ____

Are there any area of concerns about language or speech development? □ Yes □ No If yes, please explain: ________________________

When the patient is in the car, do they use? □ Infant Seat □ Booster Seat □ Seatbelt Only

Does the patient wear a helmet while riding a bike? □ Yes □ No

Do you have concerns about the patient's behavior at home or in groups with other children? □ Yes □ No

If yes, please explain: ____

For Female Patients Only: Age at first menstrual period _____________

SOCIAL HISTORY:

Are the patient's parents: □ Married □ Never Married □ Separated □ Divorced If divorced, for how long? _________________________

Mother's Employer: _________________________________ Mother's Occupation: ____

Father's Employer: __________________________________ Father's Occupation: ____

Do any household members smoke? □ Yes □ No Is violence in the home a concern? □ Yes □ No Are there guns in the home? □ Yes □ No

Would you like to speak with the physician regarding the patient's: □ Alcohol Use □ Tobacco Use □ Sexual Activity □ Aggressive Behavior

How many hours per day does the patient spend with the following: ___Watching TV ___On the Computer/iPad ___Playing Video Games

Do you have any concerns about lead exposure due to having an old home, or because of plumbing, and peeling paint? □ Yes □ No

Do you have smoke detectors in your home? □ Yes □ No

Who lives at home with the patient?

Name	Age	Relationship	Highest Level of Education

SCHOOL HISTORY:

Did/Does the patient attend school/preschool? □ Yes □ No Current grade in school? _______

Do you have concerns with how the patient is doing in school? □ Yes □ No

Any concerns about relationships with teachers or other students? □ Yes □ No

If more than 4 years old: does your child have a best friend? □ Yes □ No

Does your child play any sports? □ Yes □ No How many times a week? _________ How long (minutes) _________

FAMILY HISTORY: *Please indicate with a check (√) who in the patient's family has had the following conditions. In the first column please indicate their living status. L = Living, D = Deceased, U = Unknown.*

	Living Status	**Asthma**	**Diabetes**	**High Blood Pressure**	**Heart Disease**	**Stroke**	**Heart Attack**	**Cancer (Type)**	**Colon Polyps**	**Depression**	**Other**
Mother											
Father											
Siblings											
Maternal Grandmother											
Maternal Grandfather											
Paternal Grandmother											
Paternal Grandfather											
Other Family Members Information: *(please write in)*											

REVIEW OF SYSTEMS: *Please indicate with a check (√) any current problems your child has on the list below.*

CONSTITUTIONAL
- Fevers/chills/sweats
- Unexplained weight loss
- Fatigue/weakness
- Excessive thirst or urination

CARDIOVASCULAR
- Chest pain/discomfort
- Leg pain with exercise
- Palpitations

GASTROINTESTINAL
- Abdominal pain
- Blood in bowel movement
- Nausea/vomiting/diarrhea

NEUROLOGICAL
- Headaches
- Dizziness/light-headedness
- Numbness
- Memory loss
- Loss of coordination

EYES
- Change in vision
- Nearsighted
- Farsighted

CHEST (BREAST)
- Breast lump/discharge

GENITOURINARY
- Nighttime urination
- Incontinence
- Sexual function problems
- Discharge from penis

GYNECOLOGICAL
- Abnormal vaginal bleeding
- Problems with conception
- Problems with contraception
- Vaginal discharge
- Vaginal odor
- Painful intercourse

EARS/NOSE/THROAT/MOUTH
- Difficulty hearing/ringing in
- Hay fever/allergies
- Problems with teeth/gums

RESPIRATORY
- Cough/wheeze
- Difficulty breathing

MUSCULO-SKELETAL
- Muscle/joint pain

SKIN
- Rash or mole change(s)

PSYCHIATRIC
- Anxiety/stress
- Problems with sleep
- Depression

OTHER: ______________________________
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