

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 | Heart Disease | Vision Problems |
| Anemia | Ear Infections | Hay Fever |
| Pneumonia | Convulsions/Epilepsy | Other: _____ |
| Diarrhea | Constipation | _____ |
| Hearing Problems | Rheumatic Fever | _____ |

HOSPITALIZATIONS: 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 themselves, or feeding themselves? 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: <i>(please write in)</i>											

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: _____
