Pediatric Medical History

Child's Full Name: _____ **Nickname:** _____

Date of birth: _____/_____/_____ **Gender:** ☐ M ☐ F **Race/Ethnicity:** _____

Height: _____ **Weight:** _____ **Date of last physical examination:** _____

Name, address, and/or phone of PREVIOUS primary physician:

_____

Name, address, and/or phone of medical specialists:

_____

THESE QUESTIONS APPLY TO JUST THIS PATIENT

Is your child being treated by a physician at this time? ☐ YES ☐NO

Reason _____

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? ☐ YES ☐ NO

List name, dose, frequency & date started: _____

Has your child ever had a reaction or allergy to an antibiotic or other medication? ☐ YES ☐ NO

If yes, list: _____

Is your child allergic to latex or anything else such as metals, acrylic, or dye? ☐ YES ☐ NO

If yes, list _____

PAST MEDICAL HISTORY

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line.

Significant problems or specialty care	☐ YES	☐ NO	
Any serious injuries or accidents	☐ YES	☐ NO	
Any surgeries	☐ YES	☐ NO	Details:_____
Any hospitalizations	☐ YES	☐ NO	
Delayed or missing immunizations	☐ YES	☐ NO	
Attends daycare	☐ YES	☐ NO	
Allergies: Outdoor, indoor, or animal	☐ YES	☐ NO	
Allergies: food	☐ YES	☐ NO	
Eye conditions or corrective lenses	☐ YES	☐ NO	
Recurrent ear infections	☐ YES	☐ NO	
Other problems with ears or hearing	☐ YES	☐ NO	
Allergic rhinitis or other allergy	☐ YES	☐ NO	
Recurrent sinusitis	☐ YES	☐ NO	
Recurrent sore throat/tonsillitis	☐ YES	☐ NO	
Recurrent croup	☐ YES	☐ NO	
Recurrent bronchitis/pneumonia	☐ YES	☐ NO	

Asthma, reactive airway disease, bronchiolitis	☐ YES ☐ NO	
Heart problem or heart murmur	☐ YES ☐ NO	
Newborn/infant feeding issues	☐ YES ☐ NO	
Abdominal pain, GERD, or colitis	☐ YES ☐ NO	Details:_____
Constipation requiring doctor visits	☐ YES ☐ NO	
Bladder or kidney infection or other urologic problem	☐ YES ☐ NO	
Bed-wetting (after 5 years old)	☐ YES ☐ NO	
Gynecological problems/menstrual problems	☐ YES ☐ NO	
Male genital problems	☐ YES ☐ NO	
Sexually active	☐ YES ☐ NO	
Recurrent skin rash or eczema	☐ YES ☐ NO	
Other chronic skin problems (acne, warts, etc.)	☐ YES ☐ NO	Details:_____
Orthopedic problems	☐ YES ☐ NO	Details:_____
Concussion	☐ YES ☐ NO	
Recurrent headaches	☐ YES ☐ NO	
Seizures, developmental delays, or other neurological disorder	☐ YES ☐ NO	Details:_____
Autistic spectrum disorder	☐ YES ☐ NO	
ADD/ADHD	☐ YES ☐ NO	
Psychiatric, behavioral, emotional concerns	☐ YES ☐ NO	Details:_____
Use of alcohol or drugs	☐ YES ☐ NO	
Thyroid or other endocrine problems	☐ YES ☐ NO	
Diabetes	☐ YES ☐ NO	
Anemia, bleeding problem, or blood transfusion	☐ YES ☐ NO	
Significant family history (celiac, cholesterol, autoimmune, etc.)	☐ YES ☐ NO	Details:_____
Significant social history	☐ YES ☐ NO	Details:_____
Other infectious illnesses	☐ YES ☐ NO	
Chickenpox	☐ YES ☐ NO	

Other significant past medical history not listed above_____

_____

Further explain any "Yes" answers:_____

_____

_____ _____

Signature of Parent/Guardian **Date**

Patient AND Siblings (please print):_____

SOCIAL HISTORY

ONLY ONE PER FAMILY -- ANSWER QUESTIONS FOR ALL CHILDREN IN THE FAMILY.

Biological parents live together	☐ YES	☐ NO	
Issues with custody of your children	☐ YES	☐ NO	
Siblings	☐ YES	☐ NO	
Pets	☐ YES	☐ NO	
Smokers in the home	☐ YES	☐ NO	
Swimming pool at home	☐ YES	☐ NO	☐ N/A
Swimming pool with fence	☐ YES	☐ NO	
Guns in the home	☐ YES	☐ NO	☐ N/A
Guns are locked and kept separate from ammunition	☐ YES	☐ NO	

FAMILY HISTORY

	Father	Mother	Brother	Sister	Father's Father (Grandfather)	Father's Mother (Grandmother)	Mother's Father (Grandfather)	Mother's Mother (Grandmother)	Other:_____
Nasal allergy (hay fever)									
Asthma									
Eczema									
High cholesterol									
High blood pressure, stroke									
Heart disease (before 50)									
Heart arrythmia screen: fainting with exercise, pacemaker before 50, antiarrythmia medications									
Bleeding disorder									
Anemia									
Celiac disease									
Stomach or intestinal problems (GERD, colitis)									
Liver disease or hepatitis									
Kidney disease									
Bed-wetting (after 10 years old)									
Diabetes (before 50 years old)									
Low thryroid									
Lupus, arthritis, colitis									
Immune problems, HIV, or AIDS									
Epilepsy or convulsions									
Alcohol abuse									
Drug abuse									
Mental illness									
Autism, Aspergers									
Mental retardation									
Tuberculosis									
Deafness									
Other genetic illness or family history									

_____ _____

Signature of Parent/Guardian **Date**