CME Additional Medical History Form

Patient Name: _____
DOB: _____ Date: _____

Parent/Guardian Name: _____

Present Health Concerns (other than reason for visit): _____

*For any YES answers please explain in space provided or additional page

PREGNANCY & BIRTH:

Is the patient yours by: □Birth □Adoption □Stepchild □Temporary Placement □Other:_____

Were there any medical problems during pregnancy? □ Yes □ No _____

Were there are problems during labor and delivery? □ Yes □ No _____

Were there any problems such as needing oxygen, trouble breathing, jaundice (yellowness), etc.? □ Yes □ No

Method of Delivery: □Vaginal □ Caesarean Birth Weight/Length _____lbs. _____oz. _____in

Was your child born prematurely? □ Yes □ No _____

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

DEVELOPMENT:

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 _____

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

_____

For Female Patients Only: Age at first menstrual period _____ First Day of Last Period _____

SCHOOL HISTORY:

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

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

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

Does your child play any sports or participate in any clubs? □ Yes □ No _____

How many times a week? _____How long (minutes) _____

SAFETY HISTORY:

In the car does the patient use a booster seat or seatbelt (circle one)? □ Always □ Sometimes □ Never

Does the patient wear a helmet while riding a bike and/or roller-blading? □ Yes □ No □ N/A

Are there any guns in the home? □ Yes □ No If so, how are they stored? _____

How are medications stored in the home (even over the counter medications)? _____

ADDITIONAL REVIEW OF SYSTEMS: *Please indicate **circle** any current problems your child has on the list below and add any others or further detail in the space provided:*

CONSTITUTIONAL

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

CARDIOVASCULAR

- ☐ Chest pain/discomfort
- ☐ Leg pain with exercise
- ☐ Palpitations
- ☐ Heart murmurs
- ☐ Fainting

GASTROINTESTINAL

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

NEUROLOGICAL

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

EYES

- ☐ Change in vision
- ☐ Nearsighted
- ☐ Farsighted

CHEST (BREAST)

- ☐ Breast lump/discharge

GENITOURINARY

- ☐ Nighttime urination
- ☐ Incontinence
- ☐ Discharge
- ☐ Odor
- ☐ Pain
- ☐ History of UTI

EARS/NOSE/THROAT

- ☐ Difficulty hearing
- ☐ Ringing in ears
- ☐ Hay fever/allergies
- ☐ Problems with teeth/gums
- ☐ Bloody noses
- ☐ Sore throat

RESPIRATORY

- ☐ Cough/wheeze
- ☐ Difficulty breathing

MUSCULO-SKELETAL

- ☐ Muscle/joint pain
- ☐ Broken bones
- ☐ Weakness

SKIN

- ☐ Birthmarks _____
- ☐ Scars
- ☐ Rashes
- ☐ Lesions/moles

OTHER

- ☐ Heat/Cold intolerance
- ☐ Abnormal growth pattern
- ☐ Hair loss
- ☐ Easy bruising/bleeding

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)**	**Depression Anxiety/ Mental Health**	**History of Substance/ Alcohol Abuse**	**History of Being Abused**	**Other**
Mother											
Father											
Siblings											
Maternal Grandmother											
Maternal Grandfather											
Paternal Grandmother											
Paternal Grandfather											

Other Family Members Information: *(please write in)*