PEDIATRIC MEDICAL HISTORY FORM

Patient Name/DOB Or Sticker

Parent/Guardian Name: _____

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

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

Current Primary Care Provider: _____ Last Checkup Date: _____

Current Dental Care Provider: _____ Last Checkup Date: _____

Current or previous mental health treatment? ☐ Yes ☐ No Name: _____

PERSONAL MEDICAL HISTORY: ***Please circle if 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:_____

Hospitalizations, ER Visits, Injuries, Car Accidents, Lacerations/Stitches, Burns, Head Injuries, Ingestions

Location and Reason	Date

COMMUNICABLE DISEASES:

Has the patient ever had (circle if yes): ☐ Chickenpox ☐ Measles ☐ Mumps ☐ Ruella ☐ Meningitis ☐ Tuberculosis (TB)

PREGNANCY & BIRTH:

Is the patient yours by: ☐Birth ☐Adoption ☐Stepchild ☐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

Where was the patient born? _____ 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

SLEEP:

Hours of sleep per night? ___ Number of naps per day? _____ 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: __, # of ounces per day .

Has the patient seen a dentist? ☐ Yes ☐ No DI ate of last visit ____. Water source at home? ☐ City ☐ Well

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

SCHOOL HISTORY:

Did/Does the patient attend school? ☐ Yes ☐ No Current grade in school? _____Name _____
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? ☐ Yes ☐ No How many times a week? _How long (minutes) _____

Current or previous mental health treatment? ☐ Yes ☐ No
Name of mental health provider(s): _____

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
- ☐ 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

PSYCHIATRIC

- ☐ Anxiety/stress
- ☐ Problems with sleep
- ☐ Depression
- ☐ Self-injurious behavior
- ☐ Emotional outbursts
- ☐ Suicidal thoughts or attempts

EARS/NOSE/THROAT/MOUTH

- ☐ 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

OHTER

- ☐ 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 Abuse (type)**	**Depression Anxiety Mental Health**	**Other**
Mother											
Father											
Siblings											
Maternal Grandmother											
Maternal Grandfather											
Paternal Grandmother											
Paternal Grandfather											

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