



# 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:** \_\_\_\_\_  
 \_\_\_\_\_