MEDICAL HISTORY: PEDIATRICS

Name:_____ Date:_____

Past Medical History and Current Concerns

Diagnoses (e.g. asthma, seasonal allergies, urinary tract infections) | Behavioral problems? (e.g. anxiety, bedwetting, anger issues, attention deficit) | Abnormal growth and development? (speech, autism, short stature)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Any previous hospitalizations? _____

_____

Needs or has needed to see other doctors or consultants? _____

_____

Has this child had chicken pox? **YES** or **NO** If yes, what year?_____

Past Surgical History

Please include procedures and year performed.

Procedure Year | Procedure Year | Procedure Year

_____ _____ _____

_____ _____ _____

Maternal Birth History

Number of: Pregnancies: ____ Miscarriages: ____ Abortions: ____ Stillbirths: ____ Living Children: ____ Premature Births: ____

Age and cause of any child deaths: _____

For this child, problems during pregnancy / labor / delivery: _____

_____

Medications

Please include any prescription medications, herbal medications, and supplements or vitamins. Also indicate dosage and how often taken (eg, daily, twice a day)

_____ _____ _____

_____ _____ _____

Allergies

Please include any medicinal, food or environmental allergies. ☐ **No known drug allergies**

_____ _____ _____

Immunizations

Please indicate any vaccines you have declined or plan to refuse. ☐ **Up to date**

_____ _____ _____

Social History

Do any family members smoke? **YES** or **NO** If yes, how often (e.g. total number of packs for all smokers per day)? _____

Grade in school: _____ Name of school: _____ Attends daycare? **YES** or **NO**

Household occupants (number and relationship): _____

_____

Does this child spend significant time in another household? **YES** or **NO** Was this child adopted or ever in foster care? **YES** or **NO**

Siblings and their ages: _____

_____

Regular exercise or sports participation: _____

Pets: _____

Please circle the child's primary household's source of water: **CITY WATER** or **WELL WATER**

Any firearms in the house? **YES** or **NO** Smoke detectors in the home? **YES** or **NO** Carbon monoxide detectors in the home? **YES** or **NO**

MEDICAL HISTORY: PEDIATRICS

Family History

	No	Yes	Unsure	Age at Onset	Relationship (AND indicate maternal or paternal side)
Heart disease (e.g. heart attacks, congestive heart failure)	☐	☐	☐		
Abnormal heart rhythm (e.g. atrial fibrillation)	☐	☐	☐		
Unexplained death before age 50	☐	☐	☐		
High cholesterol	☐	☐	☐		
Hypertension	☐	☐	☐		
Stroke	☐	☐	☐		
Diabetes	☐	☐	☐		
Breast Cancer	☐	☐	☐		
Colon Cancer	☐	☐	☐		
Colon polyps	☐	☐	☐		
Lung Cancer	☐	☐	☐		
Ovarian Cancer	☐	☐	☐		
Prostate Cancer	☐	☐	☐		
Skin Cancer	☐	☐	☐		
Cancer (please name other)	☐	☐	☐		
Dementia	☐	☐	☐		
Asthma	☐	☐	☐		
Allergic rhinitis	☐	☐	☐		
COPD/emphysema	☐	☐	☐		
Arthritis (RA or older age)	☐	☐	☐		
Osteoporosis	☐	☐	☐		
Hypothyroidism (underactive)	☐	☐	☐		
Hyperthyroidism (overactive)	☐	☐	☐		
Alcoholism/Substance Abuse	☐	☐	☐		
Depression	☐	☐	☐		
Anxiety	☐	☐	☐		
Suicide	☐	☐	☐		
Trauma	☐	☐	☐		
Migraines	☐	☐	☐		
Glaucoma	☐	☐	☐		
Kidney disease	☐	☐	☐		
Parkinson's disease	☐	☐	☐		
Other illness	☐	☐	☐		