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): _____

Parental occupations: _____

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 : _____

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 GM=grandmother, GF=grandfather

	Mother	Father	Sister	Brother	Mat GM	Mat GF	Pat GM	Pat GF	Other relative (write in which one)
Heart disease (e.g. heart attacks, congestive heart failure)									
Abnormal heart rhythm (e.g. atrial fibrillation)									
Unexplained death before 50									
High cholesterol									
Hypertension									
Stroke									
Diabetes									
Breast Cancer									
Colon Cancer									
Colon polyps									
Lung Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer (write in type)									
Dementia									
Asthma									
Allergic rhinitis									
COPD/emphysema									
Rheumatoid arthritis									
Osteoarthritis									
Osteoporosis									
Hypothyroidism (underactive)									
Hyperthyroidism (overactive)									
Alcoholism/Substance Abuse									
Depression									
Anxiety									
Suicide									
Trauma									
Migraines									
Glaucoma									
Kidney disease									
Parkinson's disease									
Other illness (write in)									