

MEDICAL HISTORY: PEDIATRICS

Name: _____

Date: _____

Concerns you would like to address today:

Past Medical History Please list your child's history of medical conditions or diagnoses, e.g. asthma, allergies, ADHD

Medical Diagnoses

Mental/Behavioral Health Conditions

Prior Hospitalizations

_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Surgical History Please include procedures and year performed.

Procedure

Year

Procedure

Year

Procedure

Year

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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

Allergies Please include any medicinal or food 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**

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**

Regular exercise or sports participation: _____

Pets: _____

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

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

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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									
Atrial fibrillation									
Other arrhythmia									
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)									
Other Cancer (write in type)									
Dementia									
Asthma									
Allergic rhinitis									
COPD/emphysema									
Rheumatoid arthritis									
Osteoarthritis									
Osteoporosis									
Hypothyroidism (underactive)									
Hyperthyroidism (overactive)									
Alcohol use disorder									
Substance use disorder									
Depression									
Anxiety									
Suicide									
Migraines									
Glaucoma									
Kidney disease									
Parkinson's disease									
Other illness (write in)									