

Pediatric Medical History Form

(Ages 0-18)

Your answers on this form will help your provider understand your child's medical history. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. Thank you!

CHILD'S NAME: _____ AGE: _____ DATE of BIRTH: _____

NAME of ADULT ACCOMPANYING CHILD TO APPOINTMENT: _____

CHILD'S PREVIOUS DOCTOR / PRIMARY CARE PROVIDER: _____

What is the primary reason you are seeing the doctor today: _____

If time allows, what other issues would you like to discuss with the doctor?

1) _____

2) _____

MEDICATIONS: Prescription and non-prescription medications, inhalers, vitamins, supplements, etc:

Medication _____ Dose (eg. mg/pill) _____ How many times per day _____ Prescribed by whom: _____

MEDICATION ALLERGIES: _____ None _____ Penicillin _____ Sulfa _____ Other: _____

What type of reaction did your child have? _____

Date of most recent IMMUNIZATIONS:

_____ Hepatitis B	_____ MMR	_____ Tetanus booster (Tdap)
_____ Tetanus (DTaP/DTP/DT)	_____ Varicella (chicken pox):	_____ Hepatitis A
_____ HIB	_____ shot or illness? _____	_____ Rotavirus
_____ Polio (IPV)	_____ Influenza (Flu Shot)	_____ Gardasil (HPV)
_____ Pevnar (Pneumonia)	_____ Meningitis	_____ H1N1
_____ Pneumovax (Pneumonia)	_____ Tetanus booster (Td)	

PERSONAL MEDICAL HISTORY:

Please check (X) if your child has had any of the following medical problems:

_____ ADD/ADHD	_____ Bronchitis	_____ Reflux disease	_____ Recurrent ear infections
_____ Abdominal pain	_____ Chicken pox	_____ Headaches	_____ Urinary tract infection
_____ Acne	_____ Concussion/closed head injury	_____ Hearing problems	_____ Vesicoureteral reflux
_____ Allergic rhinitis	_____ Congenital heart disease	_____ Heart murmur	_____ Turner's Syndrome
_____ Allergies	_____ Constipation	_____ Menstrual problems	_____ Down's Syndrome
_____ Anemia	_____ Diabetes	_____ Migraines	
_____ Asthma	_____ Eczema	_____ Pneumonia	
_____ Bleeding disorder	_____ Fracture	_____ Kidney infection	
_____ Bronchiolitis			

Other problems (specify): _____

SURGICAL HISTORY:

Please circle or write in any surgeries or procedures which your child has had. Indicate the year of the procedure in the space.

_____ Appendectomy	_____ Surgery to repair a broken bone	_____ Adenoidectomy	_____ Umbilical hernia Repair
_____ Inguinal hernia repair	_____ Dental surgery	_____ PET placement	_____ Circumcision
	_____ Tonsillectomy	_____ Lymph node biopsy / excision	_____ Hypospadias repair

Other surgeries (specify type and year): _____

FEMALE HISTORY:

Age at 1st period: _____ First day of most recent period: _____ Has not yet had menses: _____

Currently pregnant? ___ Yes ___ No ___ possibly

BIRTH HISTORY:

Please indicate any medical problems during pregnancy: _____

Delivery by: ___ elective C-section ___ emergency C-section ___ forceps vaginal delivery ___ vacuum vaginal delivery ___ normal vaginal delivery. If not normal vaginal delivery, why? _____

Birth weight: _____ Birth length: _____ APGAR score: 1 minute _____ 5 minute _____

Please indicate any medical problems during the newborn period: _____

(over)

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FAMILY HISTORY: Please indicate if your child has a family history of any of the following:

Diagnosis	Family member(s)	Age at onset	Living?	Diagnosis	Family member(s)	Age at onset	Living?
ADD/ADHD	_____	_____	_____	Hemoglobinopathy	_____	_____	_____
Allergies	_____	_____	_____	Elevated cholesterol	_____	_____	_____
Asthma	_____	_____	_____	High blood pressure	_____	_____	_____
Birth defects	_____	_____	_____	Learning disability	_____	_____	_____
Cancer, type: _____	_____	_____	_____	Mental retardation	_____	_____	_____
Heart disease	_____	_____	_____	Migraines	_____	_____	_____
Hip dysplasia	_____	_____	_____	Obesity	_____	_____	_____
Deafness	_____	_____	_____	Scoliosis	_____	_____	_____
Depression	_____	_____	_____	Seizure disorder	_____	_____	_____
Developmental delay	_____	_____	_____	SIDS	_____	_____	_____
Diabetes	_____	_____	_____	Lazy eye	_____	_____	_____
Eczema	_____	_____	_____	Thyroid disease	_____	_____	_____
Genetic disorder	_____	_____	_____				

Other genetic diseases or child hood illnesses (please specify): _____

SOCIAL HISTORY: Who lives at home?

Name	Age	Occupation
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do any household members smoke? Yes No Smoke outside only? Yes No

Childcare providers: (specify who and number of days per week): _____

Are the child's parents: married, divorced, separated, living together, never together, parent in jail? _____

Uses bike/skating helmet: Yes No

Car restraints: Car seat: face rear Car seat: face front Booster Seat belt None

Carbon monoxide detector: Yes No Smoke detectors: Yes No

Radon in home: Yes No Untested Treated Firearms in the home: Yes No

Pets/animals at home: Yes No Type of animals: _____

School Name: _____ Like school? Yes No

Grade in school: _____ Truancy? Yes No

Grades earned: _____ Child's educational goals? _____

Learning disability? Yes No Special needs? Yes No

Gifted program? Yes No

Performing: Below grade level At grade level Above grade level

Has your child repeated any grades? Yes No Grades(s) _____ Why? _____

Has your child ever been suspended or expelled? Yes No Why? _____

Takes naps: Yes No Exercise / sports: _____ hours per day

Sleeps with parents: Yes No Type of exercise: _____

Sleeps through the night: Yes No Activities: _____

Minimum of 8.5 hours sleep per night: Yes No Has a job? No Yes

Nightmares / sleep problems: Yes No Has TV in bedroom? No Yes

TV / computer games: _____ hours per day

REVIEW OF SYMPTOMS: Please check (X) any current problems you have on the list below:

Constitutional	<input type="checkbox"/> Nasal drainage	Reproductive	Matabolic / Endocrine
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Ear pain	<input type="checkbox"/> Discharge from penis	<input type="checkbox"/> Cold intolerance
<input type="checkbox"/> Fever	<input type="checkbox"/> Discharge from eye	<input type="checkbox"/> Menstrual cramping	<input type="checkbox"/> Heat intolerance
<input type="checkbox"/> Lethargic	<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Excessive menstrual bleeding	<input type="checkbox"/> Excessive thirst
Gastrointestinal	<input type="checkbox"/> Pain with urination	<input type="checkbox"/> Vaginal discharge	Immunological
<input type="checkbox"/> Constipation	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Breast discharge	<input type="checkbox"/> Hay fever
<input type="checkbox"/> Diarrhea	Musculoskeletal	<input type="checkbox"/> Breast pain	Vascular
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Bone symptoms	Hematologic	<input type="checkbox"/> Cold leg or arm
Dermatologic	<input type="checkbox"/> Joint symptoms	<input type="checkbox"/> Excessive bleeding	Neuro / Psychiatric
<input type="checkbox"/> Itching	Respiratory	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Headache
<input type="checkbox"/> Rash	<input type="checkbox"/> Cough	Cardiovascular	<input type="checkbox"/> Psychiatric symptoms
HEENT	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Irregular heart beat	
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Wheezing		

(over)

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