

Do not write, stamp, punch holes or affix a sticker in this area. To reproduce, follow the printing instructions.

Pediatric Medical History

Please answer every question

Handwritten items must be entered **MANUALLY**. Fold only on the dotted lines.

Marking Instructions

Please use a #2 pencil. Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

Grid for patient's last name

PLEASE PRINT PATIENT'S FIRST NAME

Grid for patient's first name

PATIENT'S DATE OF BIRTH

Grid for patient's date of birth (Month, Day, Year)

CHILD'S MEDICAL HISTORY Please mark all items that apply:

PAST	CURRENT	
<input type="radio"/>	<input type="radio"/>	Abcess
<input type="radio"/>	<input type="radio"/>	Abnormal Heartbeat (Arrhythmia)
<input type="radio"/>	<input type="radio"/>	ADD/ADHD
<input type="radio"/>	<input type="radio"/>	Allergies (Seasonal)
<input type="radio"/>	<input type="radio"/>	Anxiety
<input type="radio"/>	<input type="radio"/>	Asthma
<input type="radio"/>	<input type="radio"/>	Autism

PAST	CURRENT	
<input type="radio"/>	<input type="radio"/>	Eczema
<input type="radio"/>	<input type="radio"/>	GERD/Reflux
<input type="radio"/>	<input type="radio"/>	Hearing Loss
<input type="radio"/>	<input type="radio"/>	Heart Murmur
<input type="radio"/>	<input type="radio"/>	Insomnia
<input type="radio"/>	<input type="radio"/>	Migraines/Headaches
<input type="radio"/>	<input type="radio"/>	Overweight/Obesity

please fold on dotted line

PAST	CURRENT	
<input type="radio"/>	<input type="radio"/>	Cancer
<input type="radio"/>	<input type="radio"/>	Congenital Heart Disease
<input type="radio"/>	<input type="radio"/>	Constipation
<input type="radio"/>	<input type="radio"/>	Depression
<input type="radio"/>	<input type="radio"/>	Diabetes (Juvenile Onset)
<input type="radio"/>	<input type="radio"/>	Down Syndrome
<input type="radio"/>	<input type="radio"/>	Ear Infection(s)

PAST	CURRENT	
<input type="radio"/>	<input type="radio"/>	Premature Birth
<input type="radio"/>	<input type="radio"/>	Scoliosis
<input type="radio"/>	<input type="radio"/>	Skin Infection
<input type="radio"/>	<input type="radio"/>	Speech Problems
<input type="radio"/>	<input type="radio"/>	Underweight
<input type="radio"/>	<input type="radio"/>	Urinary Tract Infection(s)
<input type="radio"/>	<input type="radio"/>	Wheezing

NONE OF THE ABOVE

Other (please specify):

CHILD'S FAMILY HISTORY Please mark all items that apply:

Family History Unknown Adopted

	MOTHER	FATHER	SISTER	BROTHER
ADD/ADHD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol Abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

please fold on dotted line

	MOTHER	FATHER	SISTER	BROTHER
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes Type 2 (Adult Onset)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High Cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kidney Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Migraines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seizures/Convulsions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eczema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Allergic Rhinitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bleeding Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

NONE OF THE ABOVE

Other Family History (please specify illness and relative):



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Please answer every question

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CHILD'S SURGICAL HISTORY Please mark all surgeries the PATIENT has had:

Patient has had **NO Surgeries**

Adenoids Removed

Appendix Removed

Ear Tube(s) Inserted

Heart Surgery

Hernia Repair

Tonsils Removed

Other Surgery (please specify):

CHILD'S ALLERGIES Please mark all items that apply:

MEDICATION Allergies

No Known **MEDICATION** Allergies

Codeine

Cephalosporins

NSAIDS (aspirin, ibuprofen, etc.)

Penicillin

Sulfa

Tylenol

Other Medication Allergy

(please specify):

----- please fold on dotted line -----

FOOD Allergies

No Known **FOOD** Allergies

Eggs

Fish

Seafood

Milk

Peanuts

Nuts

Soy

Wheat

Gluten

Other Food Allergy

(please specify):

ENVIRONMENTAL Allergies

No Known **ENVIRONMENTAL** Allergies

Adhesive Tape

Animal Dander

Seasonal Allergies

Bee Stings

Dust Mites

Latex

Mold

Pollen

Other Environmental Allergy

(please specify):

CHILD'S SOCIAL HISTORY Please mark all items that apply:

Child lives with:

Both Parents

Father

Mother

Grandparent(s)

Stepfather

Stepmother

Other Relative

Foster Parent

----- please fold on dotted line -----

Are there working smoke detectors in the home?

Yes

No

Does anyone in the household smoke?

Yes

No

Seatbelt use?

Always

Occasionally

Never