Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Pediatric Medical History
Age 12 and under

STAFF: Responses in boxes and handwritten items must be entered **MANUALLY**.

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH (Month / Day / Year)

Marking Instructions

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

SOCIAL HISTORY

HOME

Child lives with (mark all that apply):
both parents ○ grandparent(s) ○
father only ○ stepmother ○ other relative ○
mother only ○ stepfather ○ foster parent ○

other (please specify): _____

Number of siblings (brothers and sisters): 0 1 2 3 4 5 6 7 8+

Any concerns about lead exposure? yes ○ no ○
Are there any guns in the home? yes ○ no ○
Are there working smoke detectors in the home? yes ○ no ○
Is there any violent behavior in the family? yes ○ no ○
Does anyone in the household smoke? yes ○ no ○
Childcare situation: parents ○ daycare ○ relative ○ babysitter / nanny ○

other (please specify): _____

Television / computers / electronics hours daily: 0 1 2 3 4 5 6 7 8 9 10 11 12+

Mark any concerns about your child:
alcohol use ○ tobacco use ○ sexual activity ○ aggressive behavior ○

BIRTH HISTORY

Sex: male ○ female ○
Patient was born: on time ○ premature ○
If premature, weeks gestation: 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38
Delivery was: vaginal delivery ○ Cesarean section ○
Birth Weight:
pounds: 1 2 3 4 5 6 7 8 9 10 11 12
ounces: 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
Birth length:
inches: 13 14 15 16 17 18 19 20 21 22

Please indicate any problems during this pregnancy:
preterm labor ○ high blood pressure ○ diabetes ○ drug use ○
major abdominal injury ○ preeclampsia ○ alcohol use ○ tobacco use ○
Did baby have any problems after birth? yes ○ no ○
Is the child yours by: birth ○ adoption ○ stepchild ○ other ○
Please indicate any medical problems during the newborn period: NONE ○

_____

DEVELOPMENT

At what age did your child: sit alone_____ walk alone_____ say words_____ toilet train_____
GIRLS ONLY - Age at first menstrual period: 7 8 9 10 11 12 13 14 15 16

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NUTRITION AND FEEDING

Feeding style: breast ○ bottle ○ both ○

If breast fed, number of months: 1-5 ○ 6-10 ○ 11-15 ○ 16-20 ○ 21-25 ○ 26-30 ○ 31-35 ○ 36 or more ○

Has your child had any unusual feeding / dietary problems? yes ○ no ○

If yes, please specify: _____

Milk intake now: cow's milk ○ nonfat ○ 1% fat ○ 2% fat ○ whole ○ soy / rice milk ○

Average ounces per day

Note: 8 ounces = 1 cup _____

DENTAL HISTORY

Has the child been seen by a dentist? yes ○ no ○

If so, how often?

6 months ○ 1 year ○ 2 years ○ 3 years ○ 4 or more years ○

SLEEP

Hours per night: 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11 ○ 12 ○

Naps (number and length of time):

_____

ALLERGIES

Please indicate any allergies the patient has.

○ NO KNOWN ALLERGIES ○ Latex Rubber Allergy ○ Other: _____

Please list any medications or injections that have given the patient bad reactions. If possible, include the reactions
(hives, rash, itching, headaches, nausea, diarrhea, fainting, shock, shortness of breath, etc.)

Name of Medication	Reaction

MEDICATIONS

What medications is the patient taking at this time?
(Include prescription medications and over the counter medications or herbal supplements.
e.g. Aspirin, Motrin, Vitamins, St. John's Wort, etc.)

○ NOT ACTIVELY TAKING ANY MEDICATIONS - **PRESCRIPTION OR OTHERWISE**

Name of PRESCRIPTION MEDICATION	Dosage	Frequency

Name of OTC or HERBAL	Dosage	Frequency

IMMUNIZATIONS

child has had no immunizations ○ has had some ○ all immunizations are up to date ○

Please bring your child's immunization records to his / her appointment.

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Marking Instructions

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Fill in the complete oval as shown...

YOUR MEDICAL HISTORY

Please indicate if the PATIENT has a history of the following.
Mark all that apply. If none, mark, "NO MEDICAL HISTORY."

PAST	CURRENT		PAST	CURRENT	
○	○	ADD / ADHD	○	○	Deafness
○	○	Allergies (Seasonal)		○	Diabetes Juvenile Onset
○	○	Anemia		○	Down's Syndrome
○	○	Anxiety Disorder	○	○	Eczema
○	○	Arrhythmia	○	○	Epilepsy
	○	Asperger's	○	○	Hearing Loss
○	○	Asthma	○	○	Heart Murmur
	○	Autism	○	○	Insomnia
○	○	Cancer (Leukemia)	○	○	Migraines / Headaches
○	○	Cancer (Lymphoma)		○	Muscular Dystrophy
○	○	Gluten Enteropathy	○	○	Overweight / Obesity
	○	Congenital Heart Disease	○	○	Scoliosis
○	○	Congestive Heart Failure		○	NO MEDICAL HISTORY

SURGICAL HISTORY

Please mark all surgeries the patient has had.

○ **PATIENT HAS HAD NO SURGERIES**

○ Tonsils Removed	○ Hernia Repair	○ Ear Tube(s) Inserted
○ Adenoids Removed	○ Appendix Removed	○ Heart Surgery

Broken Bone(s) / Fracture(s) (please specify): _____

Other Surgery (please specify): _____

FAMILY MEDICAL HISTORY

Please indicate if the PATIENT'S FAMILY has a history of the following.

○ **Family History UNKNOWN** ○ **ADOPTED**

Please indicate which family member(s) have had these illnesses.	Father	Mother	Grandmother *Mother's side*	Grandfather *Mother's side*	Grandmother *Father's side*	Grandfather *Father's side*	Brother	Sister
ADD / ADHD	○	○	○	○	○	○	○	○
Alcoholism	○	○	○	○	○	○	○	○
Anxiety	○	○	○	○	○	○	○	○
Asthma	○	○	○	○	○	○	○	○
Bipolar Disorder	○	○	○	○	○	○	○	○
Cancer	○	○	○	○	○	○	○	○
Depression	○	○	○	○	○	○	○	○
Diabetes Type 1	○	○	○	○	○	○	○	○
Diabetes Type 2 (Adult Onset)	○	○	○	○	○	○	○	○
Coronary Artery Disease	○	○	○	○	○	○	○	○
High Blood Pressure	○	○	○	○	○	○	○	○
Migraines	○	○	○	○	○	○	○	○
Rheumatoid Arthritis	○	○	○	○	○	○	○	○
Seizures / Convulsions	○	○	○	○	○	○	○	○
Sickle Cell Anemia	○	○	○	○	○	○	○	○
NONE ○								