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

Pediatric Medical History

Age 12 and Under

Please answer every question.

STAFF: Responses outlined in rectangle and handwritten items must be entered MANUALLY.

Marking Instructions

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

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

The information in this form is used to populate the patient's Electronic Health Record and is necessary for MidMichigan Health to provide you with the best patient care possible. If there is information you are not comfortable completing, you may discuss this with the clinical staff in the privacy of the exam room.

CHILD'S MEDICAL HISTORY

Please mark all items that apply:

- Abnormal Heartbeat (Arrhythmia)
- ADD / ADHD
- Allergies (Seasonal)
- Anxiety
- Asperger's
- Asthma
- Autism
- Cancer
- Congenital Heart Disease
- Congestive Heart Failure
- Deafness
- Diabetes (Juvenile Onset)
- Down Syndrome
- Eczema
- Gluten Disorder
- Hearing Loss
- Heart Murmur
- History of Depression
- History of Ear Infection(s)
- History of Urinary Tract Infection(s) (UTI)
- Insomnia
- Migraines / Headaches
- Muscular Dystrophy
- Overweight / Obesity
- Premature Birth
- Scoliosis

- **NONE OF THE ABOVE**

FAMILY MEDICAL HISTORY

- **Family History UNKNOWN**
- **ADOPTED**

Please indicate which family member(s) have had these illnesses:	Father	Mother	Brother	Sister	Other Relative
ADD / ADHD					
Alcohol Abuse					
Anxiety					
Asthma					
Cancer					
Depression					
Diabetes Type 2 (Adult Onset)					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Kidney Disease					
Migraines					
Rheumatoid Arthritis					
Seizures / Convulsions					
Suicide Attempt					
NONE					

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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): _____

IMMUNIZATIONS

Please mark the item that applies:

- Child has had no immunizations.
- Child has had some immunizations.
- All immunizations are up to date.

PEDIATRIC SOCIAL HISTORY

Please answer the following questions:

Child lives with (mark all that apply)**:**

- both parents
- father
- mother
- grandparent(s)
- stepfather
- stepmother
- other relative
- foster parent
- other (please specify): _____

Does your child receive dental care?	yes	no
Are there working smoke detectors in the home?	yes	no
Does anyone in the household smoke?	yes	no
Are there pets in the home?	yes	no
How do you heat your home?	wood gas electric space heater	
Do you have a childcare provider?	yes	no
Do you have any concerns about your child's nutrition?	yes	no
Does your child have a car seat / booster seat?	yes	no

DOMESTIC VIOLENCE

The following question provides valuable information to assist us with treating your child's overall personal health. If you are not comfortable with answering this question, you may discuss this matter with your provider.

Are you or the child concerned about any abuse in the home? yes no