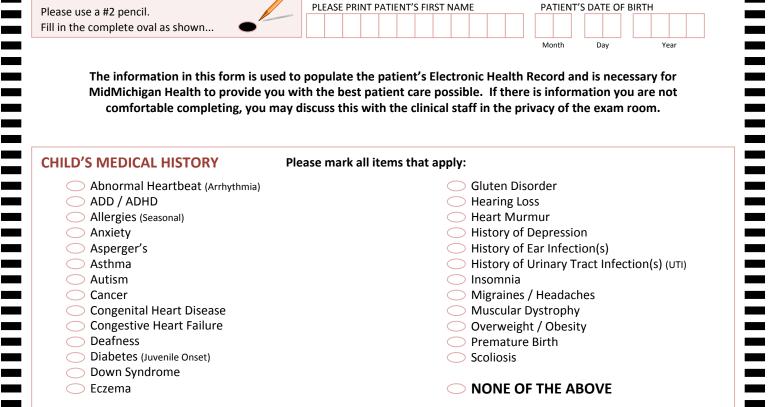
Print in Color or Grayscale Only Using Adobe Acrobat Reader 8.0 or later	Pediatric Medical History Age 12 and Under Please answer every question.	STAFF: Responses outlined in rectangle and handwritten items must be entered MANUALLY.
Marking Instructions		
Please use a #2 pencil. Fill in the complete oval as shown	PLEASE PRINT PATIENT'S 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.



FAMILY MEDICAL HISTORY

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

Page 1 of 2

SURGICAL HISTORY Pleas	e mark all surgeries the <u>PATIENT</u> 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 <u>the</u> item that applies:		
	Child has had no immunizations. Child has had some immunizations. All immunizations are up to date.		
PEDIATRIC SOCIAL HISTORY P	lease answer the following questions:		
	 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	O no
Does anyone in the household smoke	?	🔘 yes	<u> </u>
Are there pets in the home? How do you heat your home?		yes wood gas electric space heat	o no
Do you have a childcare provider?		🔘 yes	no
Do you have any concerns about your Does your child have a car seat / boos		yes yes	no no
	valuable information to assist us with treating with answering this question, you may discuss		-
Are you or the child concerned abo	ut any abuse in the home?	yes	no

Page 2 of 2

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