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Direction of Feed

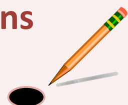
Pediatric Medical History

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

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH
Month Day Year

CHILD'S MEDICAL HISTORY

Please mark all items that apply:

PAST	CURRENT		PAST	CURRENT	
○	○	Abcess	○	○	Eczema
○	○	Abnormal Heartbeat (Arrhythmia)	○	○	GERD/Reflux
○	○	ADD/ADHD	○	○	Hearing Loss
○	○	Allergies (Seasonal)	○	○	Heart Murmur
○	○	Anxiety	○	○	Insomnia
○	○	Asthma	○	○	Migraines/Headaches
○	○	Autism	○	○	Overweight/Obesity

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PAST	CURRENT		PAST	CURRENT	
○	○	Cancer	○	○	Premature Birth
○	○	Congenital Heart Disease	○	○	Scoliosis
○	○	Constipation	○	○	Skin Infection
○	○	Depression	○	○	Speech Problems
○	○	Diabetes (Juvenile Onset)	○	○	Underweight
	○	Down Syndrome	○	○	Urinary Tract Infection(s)
○	○	Ear Infection(s)	○	○	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	○	○	○	○
Alcohol Abuse	○	○	○	○
Anxiety	○	○	○	○
Asthma	○	○	○	○

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	MOTHER	FATHER	SISTER	BROTHER
Cancer	○	○	○	○
Depression	○	○	○	○
Diabetes Type 2 (Adult Onset)	○	○	○	○
Heart Disease	○	○	○	○
High Blood Pressure	○	○	○	○
High Cholesterol	○	○	○	○
Kidney Disease	○	○	○	○
Migraines	○	○	○	○
Seizures/Convulsions	○	○	○	○
Eczema	○	○	○	○
Allergic Rhinitis	○	○	○	○
Bleeding Disorders	○	○	○	○

○ **NONE OF THE ABOVE**

Other Family History (please specify illness and relative): ______

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Direction of Feed

Pediatric Medical History

Please answer every question

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

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): ____________________

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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

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