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Using Adobe Acrobat Reader 8.0 or later

Pediatric Medical History

Please answer every question.

STAFF: Responses in boxes 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

REASON FOR VISIT TODAY

What is the reason for today's visit?

abdominal pain ◯ diarrhea ◯ liver disease ◯ feeding issues ◯ vomiting ◯ growth concerns ◯ constipation ◯ bleeding ◯ other (please specify): ◯ _____

PATIENT MEDICAL HISTORY

Please mark all conditions the patient has had:

- ◯ ADD / Hyperactivity
- ◯ Alcohol Problems
- ◯ Allergies (Food / Environmental)
- ◯ Anemia
- ◯ Anxiety Disorders
- ◯ Arthritis
- ◯ Asthma
- ◯ Autism
- ◯ Bipolar Disorder
- ◯ Birth Defects
- ◯ Bleeding Problems
- ◯ Blindness
- ◯ Blood Transfusion
- ◯ Cancer
- ◯ Cataracts
- ◯ Celiac Disease
- ◯ Colitis / Ulcerative Colitis
- ◯ Congenital Heart Condition
- ◯ Convulsions (Epilepsy / Seizures)
- ◯ Crohn's Disease
- ◯ Cystic Fibrosis
- ◯ Depression
- ◯ Diabetes
- ◯ Gallbladder Disease
- ◯ High Blood Pressure
- ◯ Kidney Disease
- ◯ Liver Disease
- ◯ Migraine Headaches
- ◯ Muscle Disease
- ◯ Polyps
- ◯ Psychiatric Illness
- ◯ Sickle Cell Disease / Trait
- ◯ Stomach Problems
- ◯ Stroke
- ◯ Substance Abuse
- ◯ Thyroid Disorders
- ◯ Tooth Enamel Problems
- ◯ Other (please specify): _____

SOCIAL HISTORY

Is the patient adopted? ◯ yes ◯ no

Does the patient attend daycare? ◯ yes ◯ no

Who has legal custody of the patient? ◯ both parents ◯ mom ◯ dad ◯ grandparent(s) ◯ courts ◯ other

TOBACCO USE

Does anyone smoke around the patient? ◯ yes ◯ no

Does the patient smoke cigarettes?

◯ never ◯ in the past ◯ current (some days) ◯ current (every day)

How many packs per day do they (or did they) smoke? ◯ <1 ◯ 1-2 ◯ >2

How many years have they (or did they) smoke? ◯ <1 ◯ 1-2 ◯ >2

Do they use other tobacco products? ◯ never ◯ in the past ◯ currently

DRUG USE

Has the patient used recreational / illicit drugs currently or in the past? ◯ yes ◯ no

If yes, for how many years? ◯ <1 ◯ 1-2 ◯ 3-4 ◯ 5-6 ◯ 7-8

SCHOOL

What grade is the patient in school? ◯ pre-k ◯ kindergarten ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ 11 ◯ 12

What is the name of the patient's school? _____

In the past year, how many days of school did the patient miss due to illness?

◯ 1-5 ◯ 6-10 ◯ 11-20 ◯ >20

Does the patient participate in sports? ◯ yes ◯ no

Is there a history of physical / sexual abuse to the patient? ◯ yes ◯ no

FAMILY CHANGES

Please mark all changes that have recently occurred in the patient's family:

- ◯ a new child
- ◯ a death
- ◯ a divorce
- ◯ patient has lived away from home
- ◯ a job change
- ◯ a serious illness
- ◯ a marriage

Pediatric Medical History

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SURGICAL AND HOSPITALIZATION HISTORY

SURGERIES

Has the patient ever had any surgery? yes ◯ no ◯

If yes, please mark all surgeries the patient has had:

◯ Tonsils ◯ Ear Tubes ◯ Tracheostomy
◯ Adenoids ◯ Hernia Repair ◯ Other (please specify): _____

HOSPITALIZATION

Has the patient ever been hospitalized? yes ◯ no ◯

If yes, please list the reason for hospitalization and the approximate date:

_____

_____

ANESTHESIA

Has the patient ever had any problems with anesthesia? yes ◯ no ◯

If yes, please list the reactions the patient had and approximate date:

_____

FAMILY MEDICAL HISTORY

Please mark all conditions the patient's family has had.
If you do not know of any family members with a condition, mark "Unaware."

◯ **PATIENT'S FAMILY HISTORY UNKNOWN**
◯ **NO SIGNIFICANT FAMILY MEDICAL HISTORY**

	Father	Mother	Brother	Sister	Grandparent	Other	Unaware
Alcohol Problems	◯	◯	◯	◯	◯	◯	◯
Allergies (Food / Environmental)	◯	◯	◯	◯	◯	◯	◯
Anemia	◯	◯	◯	◯	◯	◯	◯
Asthma	◯	◯	◯	◯	◯	◯	◯
Attention Deficit Disorder / Hyperactivity	◯	◯	◯	◯	◯	◯	◯
Bipolar Disorder	◯	◯	◯	◯	◯	◯	◯
Birth Defects	◯	◯	◯	◯	◯	◯	◯
Cancer	◯	◯	◯	◯	◯	◯	◯
Celiac Disease	◯	◯	◯	◯	◯	◯	◯
Coagulation Problems	◯	◯	◯	◯	◯	◯	◯
Colitis / Ulcerative Colitis	◯	◯	◯	◯	◯	◯	◯
Convulsions (Epilepsy / Seizures)	◯	◯	◯	◯	◯	◯	◯
Crohn's Disease	◯	◯	◯	◯	◯	◯	◯
Depression	◯	◯	◯	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯	◯	◯	◯
Easy Bruising	◯	◯	◯	◯	◯	◯	◯
Gallbladder Disease	◯	◯	◯	◯	◯	◯	◯
Growth / Developmental Disorders	◯	◯	◯	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯	◯	◯	◯
Hypertension (High Blood Pressure)	◯	◯	◯	◯	◯	◯	◯
Kidney Disease	◯	◯	◯	◯	◯	◯	◯
Liver Disease	◯	◯	◯	◯	◯	◯	◯
Migraine Headaches	◯	◯	◯	◯	◯	◯	◯
Osteoporosis	◯	◯	◯	◯	◯	◯	◯
Polyps	◯	◯	◯	◯	◯	◯	◯
Psychiatric Illness	◯	◯	◯	◯	◯	◯	◯
Sickle Cell Disease / Bleeding Problems	◯	◯	◯	◯	◯	◯	◯
Stomach Problems	◯	◯	◯	◯	◯	◯	◯
Thyroid Disease	◯	◯	◯	◯	◯	◯	◯
Tooth Enamel Problems	◯	◯	◯	◯	◯	◯	◯

Other (please specify condition and family member):

_____

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CURRENT CONDITIONS

Has the patient recently or currently had any of these symptoms or conditions? Mark all that apply. If no symptoms, mark "NONE".

GASTROINTESTINAL	Polyps	Colitis / Ulcerative Colitis
	Abdominal Pain	Heartburn
	Trouble Swallowing	Colic
	Painful Swallowing	Diarrhea
	Bad Breath (Halitosis)	Constipation
	Nausea / Vomiting	Rectal Bleeding
	Irritable Bowel	Change in Bowel Movements
	Bloating	Weight Loss
	Crohn's Disease	NONE
HEPATIC	Hepatitis	Jaundice
	Pancreatitis	NONE
CARDIOVASCULAR	Blood Pressure Problems	Irregular Heartbeat
	Heart Murmur	
	Chest Pain	NONE
RESPIRATORY	Chronic Cough	Asthma
	Choking with Food	Pneumonia
	Bronchitis	
	Hoarseness	NONE
GENITOURINARY	Frequent Urinary Tract Infections	
	Kidney Stones	NONE
ENDOCRINE / METABOLIC	Cold Intolerance	NONE
NEUROLOGIC	Migraines / Headaches	Seizures
	Weakness	NONE
MUSCULOSKELETAL	Joint Pain / Swelling	Back Pain
	Neck Pain	NONE
BLOOD DISORDERS	Clotting Problems	Anemia
	Easy Bruising	
	Easy Bleeding	NONE
SKIN	Rash	
	Bruises	NONE
EYES	Blurred or Double Vision	
	Blindness	NONE
EAR, NOSE & THROAT	Loose Teeth	Deafness
	Enamel Problems	
	Nosebleeds	NONE
PSYCHOSOCIAL	Mood Changes	NONE

OTHER (Please list any symptoms / illnesses not listed above):

_____

_____

Is the patient's family physician aware of any of the symptoms / illnesses that have been marked?

yes ○ no ○ not applicable ○

ALLERGIES

Please list allergies the patient has. (Include environmental, medication, food allergies and reaction to previous blood transfusion.)

○ **PATIENT HAS NO KNOWN ALLERGIES**

Substance	Reaction	Substance	Reaction

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MEDICATIONS

Please list all medications the patient is currently taking. (Include over-the-counter, prescriptions, birth control, etc.)

○ **PATIENT IS TAKING NO MEDICATIONS**

Name of Medication	Dosage	Frequency

Name of Medication	Dosage	Frequency

IMMUNIZATIONS

Are the patient's immunizations up to date? yes ○ no ○ unknown ○

Has the patient had the following immunizations?

- **Hepatitis A** yes ○ no ○ unknown ○
- **Hepatitis B** yes ○ no ○ unknown ○
- **Varicella** (Chicken Pox) yes ○ no ○ unknown ○
- **Meningococcal** yes ○ no ○ unknown ○

BIRTH HISTORY

How much did the patient weigh at birth?

POUNDS 0 ○ 10 ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○

OUNCES 0 ○ 10 ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○

Was the patient's birth premature or full term? premature ○ full term ○

The patient's MOTHER:

First and last name: _____ Occupation: _____

The patient's FATHER:

First and last name: _____ Occupation: _____

How many brothers and sisters does the patient have?

0 ○ 1 ○ 2 ○ 3 ○ 4 ○ > 5 ○

FEMALES ONLY

Has the patient started having periods? yes ○ no ○

If yes, how old was the patient when she had her first period?

8 ○ 9 ○ 10 ○ 11 ○ 12 ○ 13 ○ 14 ○ 15 ○ 16+ ○

Date of last period: _____

Mark all problems that the patient has regarding her period:

- a lot of cramping ○
- very heavy flow ○
- periods that last more than 5 days ○
- irregular periods (periods that do not occur every month) ○
- other ○

Does the patient use any birth control methods for any reason? (e.g., pills, patch, shot, etc.) yes ○ no ○

Has the patient ever been pregnant? yes ○ no ○

PATIENTS UNDER 1 YEAR OF AGE ONLY

If the patient was breastfed, how many months? 0-3 ○ 4-6 ○ 7-11 ○ >11 ○

If the patient was bottle fed, which formula? cow's milk ○ soy ○ other ○

Do you need to change formula? yes ○ no ○

Did the patient have a bowel movement the first day of life? yes ○ no ○