

Pediatric Medical History Form

Please complete All **3** PAGES

Name

DOB

Your answers on this form will help your clinician understand your medical concerns and conditions better. This form will NOT be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you!**

PRESENT HEALTH CONCERNS: _____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

Medication	Dose	Times per day

Medication	Dose	Times per day

ALLERGIES or REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:

Medication/Food/Other Agent	Reaction or Side Effect

SURGICAL HISTORY (Please list all prior operations and dates):

Operation	Date

PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis):

- | | | |
|--|---|--|
| <input type="checkbox"/> Congenital Heart disease:
<i>specify type</i> _____ | <input type="checkbox"/> Anemia | <input type="checkbox"/> Murmur |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Respiratory Distress Syndrome |
| <input type="checkbox"/> Thyroid problem
<i>specify type</i> _____ | <input type="checkbox"/> Enterocoloitis – Necrotizing | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Cancer (Malignancy)
<i>specify type</i> _____ | <input type="checkbox"/> Esophageal Reflux | Other Problems
_____ |
| <input type="checkbox"/> Depression/suicide attempt | <input type="checkbox"/> Feeding Problem | _____ |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Fracture (specify site)
_____ | _____ |
| <input type="checkbox"/> If you have ever had a blood
transfusion, please specify date
_____ | <input type="checkbox"/> Headache | _____ |
| <input type="checkbox"/> Abnormal Pap smear | <input type="checkbox"/> Hearing Loss | When was your last Tetanus shot?
_____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Intracranial Hemorrhage | _____ |

SOCIAL HISTORY

SUBSTANCES

Tobacco Use

Cigarettes

Quit: Date _____

Never

Current: Smoker: packs/day _____ # of yrs _____

Other Tobacco: Pipe Cigar Snuff Chew

Are you interested in quitting? No Yes

Alcohol Use? No Yes If Yes, How many ounces per week? _____

Other Substance use? No Yes

EXERCISE:

Do you exercise regularly? No Yes

SELF-EXAMS:

Breast Exam No Yes NA

Testicular Exam No Yes NA

SOCIOECONOMICS:

Occupation: _____

Education completed: Grade school High school College Graduate school Years of education _____

Marital status: Single M Sep D W Co-habiting Engaged Other: _____

Who lives at home with you? _____

SEXUALITY

Sexual Activity

Sexually Active: Yes No Not currently

Current sex partner(s) is/are: male female

Contraception and Protection

Birth Control method: _____ None needed

If sexually active, do you practice safe sex? NA No Yes

Have you ever had any sexually transmitted diseases (STDs)? No Yes

If yes, please include: _____ date _____

_____ date _____

Are you interested in being screened for sexually transmitted diseases? No Yes

Other concerns? _____

SAFETY:

Do use seatbelts/carseats consistently? No Yes

Do you use a bike helmet regularly? NA No Yes

Other concerns? _____

HOSPITAL INFO:

What Hospital was the patient born at? (Only answer if patient under age 5) _____

This page only needs to be filled out one time per family. Thank you.

Please list all siblings this pertains to:

Name	DOB

FAMILY HISTORY:

Please indicate with a check (✓) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other close relatives	Medical Condition	Mom	Dad	Sist.	Bro.	Daug.	Son	Other close relatives
Alcoholism								Hay fever (Allergic Rhinitis)							
Allergies								Hearing problems							
Arrhythmia								Heart Attack (Coronary Artery Disease)							
Anesthesia problem								Heart Disease-Congenital							
Arthritis								Hemoglobinopathy							
Asthma								High Blood Pressure (Hypertension)							
AutoImmune Disease								High cholesterol (Hyperlipidemia)							
Birth Defects								Inflammatory Bowel Dis.							
Bleeding problem								Kidney diseases							
Cancer, Breast								Mental retardation							
Cancer (not noted)								Migraine headaches							
Congenital Anomaly								Mitral Valve Prolapse							
Depression								Neuromuscular Disorder							
Diabetes, Type 1 (childhood onset)								Osteoporosis							
Diabetes, Type 2 (adult onset)								Psychiatric Illness							
Eczema								Stroke							
Epilepsy(seizures)								Thyroid disorders							
Genetic diseases								Tuberculosis							
Glaucoma								Other:							
GU Reflux															

PHARMACY INFO:

Which pharmacy do you use? (Please specify name and location) _____