PEDIATRIC PATIENT MEDICAL HISTORY FORM

Date	Child's Name	Nickname	DOB	M F

Previous Physician	Request for Records Transfer Complete Y N	Date of Last Well Child Exam

Mother's Full Name	Father's Full Name
Step-Mother's Full Name (If Applicable)	**Step-Father's Full Name (If Applicable)**
Custodial Provider's Full Name (If different from above)	**Relationship to Patient**

Birth History

Birth Weight _____ Preg#_____ Mom's age_____ Was the birth □ Vaginal ? □ Cesarean? □ Early? □ Late?

If birth was early, how many weeks early? _____ If Cesarean, why? _____

Did mother have any illnesses/problems with her pregnancy? □ Yes □ No Explain _____

Did baby have any problems right after birth? □ Yes □ No Explain_____

Before mother knew she was pregnant or at any time during her pregnancy did she:

□ Smoke Cigarettes (amount)_____ □ Drink Alcohol (amount) _____

□ Use "street" drugs (type)_____ □ Use Prescription Drugs (type)_____

Was initial feeding □ Breast Milk? □ Formula?

Current and Past History

Is your child currently on any medication?	□ Y	□ N	Explain_____
Does your child have any serious or chronic illnesses?	□ Y	□ N	Explain_____
Has your child had serious injuries or accidents?	□ Y	□ N	Explain_____
Has your child had any surgeries?	□ Y	□ N	Explain_____
Has your child ever been hospitalized?	□ Y	□ N	Explain_____
Is your child allergic to any medications?	□ Y	□ N	Explain_____
Has your child ever reacted to immunizations?	□ Y	□ N	Explain_____

Does Your Child Have Or Has Your Child Ever Had:

Asthma, recurrent cough, bronchitis, or pneumonia	□ Y	□ N	Explain_____
Nasal allergies or eczema	□ Y	□ N	Explain_____
Frequent ear infections or sore throat	□ Y	□ N	Explain_____
Problems with ears or hearing	□ Y	□ N	Explain_____
Problems with eyes, vision or teeth	□ Y	□ N	Explain_____
Frequent headaches or other neurologic problems	□ Y	□ N	Explain_____
Frequent abdominal pain	□ Y	□ N	Explain_____
Constipation requiring doctor visits	□ Y	□ N	Explain_____
Bladder/kidney problems or bedwetting	□ Y	□ N	Explain_____
Any heart problems/murmur	□ Y	□ N	Explain_____
Anemia or bleeding problem	□ Y	□ N	Explain_____
Thyroid or other gland problem	□ Y	□ N	Explain_____
Diabetes	□ Y	□ N	Explain_____
ADD/ADHD	□ Y	□ N	Explain_____
Mental Health Issues	□ Y	□ N	Explain_____
Use of drugs or alcohol	□ Y	□ N	Explain_____

Household Information

Please List All Those Living in the Child's Home		
Name	**Relationship to Child**	**DOB**

Are there siblings not listed above? If so, please list their full names and ages and where they live. _____
_____
_____

Child Care:_____

Smokers in household? □ Y □ N

Family Medical History (Parents, Siblings, Grandparents, Aunts and Uncles)

Have Any Family Members Had the Following:

Alcohol/Drug Abuse	□ Y	□ N	Who_____	Comments_____
Allergies	□ Y	□ N	Who_____	Comments_____
Asthma	□ Y	□ N	Who_____	Comments_____
Birth Defects	□ Y	□ N	Who_____	Comments_____
Blood Disorders	□ Y	□ N	Who_____	Comments_____
Bone Disorders	□ Y	□ N	Who_____	Comments_____
Cancer	□ Y	□ N	Who_____	Comments_____
Diabetes	□ Y	□ N	Who_____	Comments_____
Endocrine Disease	□ Y	□ N	Who_____	Comments_____
Ear/Nose/Throat Disorders	□ Y	□ N	Who_____	Comments_____
Eye Disorders	□ Y	□ N	Who_____	Comments_____
Gastrointestinal Disorders	□ Y	□ N	Who_____	Comments_____
Heart Disease	□ Y	□ N	Who_____	Comments_____
High Blood Pressure	□ Y	□ N	Who_____	Comments_____
High Cholesterol	□ Y	□ N	Who_____	Comments_____
Immune Disorders	□ Y	□ N	Who_____	Comments_____
Joint Problems	□ Y	□ N	Who_____	Comments_____
Kidney Disease	□ Y	□ N	Who_____	Comments_____
Liver Disease	□ Y	□ N	Who_____	Comments_____
Lung Disease	□ Y	□ N	Who_____	Comments_____
Migraine Headaches	□ Y	□ N	Who_____	Comments_____
Metabolic Disorders	□ Y	□ N	Who_____	Comments_____
Obesity	□ Y	□ N	Who_____	Comments_____
Seizure Disorders	□ Y	□ N	Who_____	Comments_____
Skin Disorders	□ Y	□ N	Who_____	Comments_____
Stroke History	□ Y	□ N	Who_____	Comments_____
Thyroid Disorders	□ Y	□ N	Who_____	Comments_____
Mental Health History	□ Y	□ N	Who_____	Comments_____
Other Medical History	□ Y	□ N	Who_____	Comments_____
Other Medical History	□ Y	□ N	Who_____	Comments_____