

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	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Allergies	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Asthma	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Birth Defects	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Blood Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Bone Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Cancer	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Diabetes	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Endocrine Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Ear/Nose/Throat Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Eye Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Gastrointestinal Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Heart Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
High Blood Pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
High Cholesterol	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Immune Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Joint Problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Kidney Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Liver Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Lung Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Migraine Headaches	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Metabolic Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Obesity	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Seizure Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Skin Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Stroke History	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Thyroid Disorders	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Mental Health History	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Other Medical History	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____
Other Medical History	<input type="checkbox"/> Y	<input type="checkbox"/> N	Who _____	Comments _____