

MEDICAL HISTORY: PEDIATRICS

Name: _____

Date: _____

Past Medical History and Current Concerns

Recurrent illness? (e.g. asthma, seasonal allergies, urinary tract infections)

Behavioral problems? (e.g. anxiety, bedwetting, anger issues, attention deficit)

Abnormal growth and development? (speech, autism, short stature)

Any previous hospitalizations? _____

Needs or has needed to see other doctors or consultants? _____

Has this child had chicken pox? **YES** or **NO**

Past Surgical History Please include procedures and year performed.

Procedure

Year

Procedure

Year

Procedure

Year

Maternal Birth History

Number of: Pregnancies: ____ Miscarriages: ____ Abortions: ____ Stillbirths: ____ Living Children: ____ Premature Births: ____

Age and cause of any child deaths: _____

For this child, problems during pregnancy / labor / delivery: _____

Medications Please include any prescription medications, herbal medications, and supplements or vitamins. Also indicate dosage and how often taken (eg, daily, twice a day)

Allergies Please include any medicinal, food or environmental allergies. No known drug allergies

Immunizations Please indicate any vaccines you have declined or plan to refuse. Up to date

Social History

Do any family members smoke? **YES** or **NO** If yes, how often (e.g. total number of packs for all smokers per day)? _____

Grade in school: _____ Name of school: _____ Attends daycare? **YES** or **NO**

Household occupants (number and relationship): _____

Does this child spend significant time in another household? **YES** or **NO** Was this child adopted or ever in foster care? **YES** or **NO**

Siblings and their ages: _____

Regular exercise or sports participation: _____

Pets: _____

Please circle the child's primary household's source of water: **CITY WATER** or **WELL WATER**

Any firearms in the house? **YES** or **NO** Smoke detectors in the home? **YES** or **NO** Carbon monoxide detectors in the home? **YES** or **NO**

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Family History

	No	Yes	Unsure	Age at Onset	Relationship (AND indicate maternal or paternal side)
Heart disease (e.g. heart attacks, congestive heart failure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Abnormal heart rhythm (e.g. atrial fibrillation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Unexplained death before age 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Colon polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Cancer (please name other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Allergic rhinitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
COPD/emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Arthritis (RA or older age)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hypothyroidism (underactive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hyperthyroidism (overactive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Alcoholism/Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		