(PEDIATRIC HISTORY FORM)

PATIENT NAME: _____ DATE COMPLETED: _____

DATE OF BIRTH: _____ SEX: Male ☐ Female ☐

FORM COMPLETED BY: _____ RELATIONSHIP TO PATIENT: _____

CURRENT MEDICAL HISTORY:

Is your child having any medical problems? ☐Yes ☐No

If yes, please list: _____

_____

Do you consider your child to be in good health? ☐Yes ☐No

Current medications: _____

_____

DRUG ALLERGIES? ☐Yes ☐No ***If yes, please check:*** ☐ Aspirin ☐Codeine ☐Tetracycline ☐Mycins ☐ Sulfa ☐ Morphine

☐**Other: Please list:** _____

Are Immunizations up-to-date? ☐Yes ☐No *(Please provide a copy of immunization record)*

Please indicate the date of your:

Last Tetanus Shot _____ Last eye exam _____ LMP _____ Flow: Light / Med / Heavy

Last Flu Shot _____ Last dental exam _____ Are you pregnant? _____ Number of children _____

Last TB Test _____ Last PAP (women) _____

LIFESTYLE: ***If sexually active, how many lifetime partners?*** _____ ***Any history of STD's*** _____ ***type?*** _____

Do you currently smoke: ☐cigarettes _____packs per day ____# of yrs ☐cigars ☐pipes ☐Use chewing tobacco or snuff?

If you are a smoker, are you aware of all the health hazards associated with smoking? ☐Yes ☐No

Would you like to participate in a smoking cessation program? ☐Yes ☐No

Drug/Alcohol/ Caffeine use: ☐ Marijuana ☐ Speed / amphetamines ☐Heroin ☐Alcohol ☐Pop/Soda

☐ Cocaine / Crack ☐ Prescription drugs ☐Other ☐Coffee ☐Energy Drinks

Do you exercise regularly? ☐No ☐ Yes, please list type and amount _____

FAMILY HISTORY:

If a family member has or has had any of the following problems, check the appropriate box and list the family member:

M=Mother F=Father S=Sibling GM=Grandmother GF=Grandfather A=Aunt U=Uncle

☐_____Deafness	☐_____Immunity problems / HIV	☐_____Stomach / GI
☐_____Allergies	☐_____High cholesterol	☐_____Cancer
☐_____Drug Allergies	☐_____High blood pressure before 50 yrs	☐_____Epilepsy or convulsions
☐_____Asthma	☐_____Heart attack / stroke before 50 yrs	☐_____Hereditary problems
☐_____Eczema	☐_____Other heart problems	☐_____Learning problems / Attention Span
☐_____Respiratory infections	☐_____Anemia / Blood disorders	☐_____Emotional / Behavioral
☐_____Eye or visual problems	☐_____Diabetes before 50 yrs	☐_____Mental illness
☐_____Ear infections / tubes	☐_____Thyroid or other endocrine problems	☐_____Mental retardation
☐_____Tuberculosis	☐_____Obesity	☐_____Drug / Alcohol abuse
☐_____Liver disease	☐_____Bladder / Kidney	☐_____Other

PATIENT NAME: DATE OF BIRTH:

REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY:

Does the patient have or has ever had any of the following? ***EXPLAIN:***

a serious medical problem? ☐ Yes ☐ No _____

been hospitalized or had surgery? ☐ Yes ☐ No _____

had a serious injury or accident? ☐ Yes ☐ No _____

chickenpox? When? _____ ☐ Yes ☐ No _____

allergies, asthma, bronchitis or respiratory infections? ☐ Yes ☐ No _____

repeated ear infections, tubes or difficulty hearing? ☐ Yes ☐ No _____

problems with eyes or vision? ☐ Yes ☐ No _____

heart problems or a heart murmur? ☐ Yes ☐ No _____

anemia, bleeding problems or blood transfusion? ☐ Yes ☐ No _____

abdominal pain, constipation requiring doctor visits? ☐ Yes ☐ No _____

recurrent vomiting, recurrent diarrhea, blood in stools? ☐ Yes ☐ No _____

bladder or kidney infections, bed-wetting after 5 yrs? ☐ Yes ☐ No _____

recurrent skin problems (acne, eczema, etc)? ☐ Yes ☐ No _____

headaches, convulsions, other neurological problems? ☐ Yes ☐ No _____

diabetes, thyroid or other endocrine problems? ☐ Yes ☐ No _____

(girls) has she started her menstrual periods? ☐ Yes ☐ No _____

If yes, is she having any problems? ☐ Yes ☐ No _____

DEVELOPMENT:

Are you concerned about the patient's..... ***EXPLAIN:***

physical development? ☐ Yes ☐ No _____

mental or emotional deveopment? ☐ Yes ☐ No _____

learning ability? ☐ Yes ☐ No _____

attention span or activity level? ☐ Yes ☐ No _____

If in school, has the patient had.....

tutoring outside of the classroom or had to repeat a grade? ☐ Yes ☐ No _____

placement in a special or resource class? ☐ Yes ☐ No _____

educational or psychological testing? ☐ Yes ☐ No _____

behavioral problems? ☐ Yes ☐ No _____

SAFETY & PREVENTION:

Does your child use a car seat, booster seat and/or seatbelt at all times when in a car? ☐ Yes ☐ No

Does your child wear a helmet when riding a bicycle? ☐ Yes ☐ No

Does your child wear protective gear when participating in sporting activities? ☐ Yes ☐ No

Does your child see a dentist for regular check ups? ☐ Yes ☐ No

Do you have working smoke detectors in your home? ☐ Yes ☐ No

Do you take safety precautions with firearms in the home? ☐ Yes ☐ No

Does anyone smoke in the home or car around your child? ☐ Yes ☐ No