PEDIATRIC MEDICAL HISTORY

PATIENT NAME:_____ **DOB:**_____**TODAY'S DATE:**_____

REASON FOR TODAY'S VISIT_____

PREVIOUS TREATMENT FOR THIS PROBLEM_____

ALL SURGERIES	DATE OF SURGERY	DRUG ALLERGIES ☐ NONE	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALL MEDICAL PROBLEMS	CURRENT MEDICATIONS AND DOSES
_____	_____
_____	_____
_____	_____

FAMILY MEDICAL HISTORY

Mother: ☐ Alive Died age _____ Significant Medical Problems _____

Father: ☐ Alive Died age _____ Significant Medical Problems _____

Siblings: ____# sisters & _____# brothers Significant Medical Problems _____

SOCIAL HISTORY

Born full term ☐ Yes ☐ No Premature # weeks ___ Pregnancy complications: _____ Birth Complications:_____

Newborn hearing screen ☐ Passed ☐ Failed Vaccinations up to date: Yes ☐ No ☐

Lives with both parents: ☐ Yes ☐ No Daycare ☐ School ☐ Home Schooled ☐ Foster care ☐

Exposure to second hand smoke: ☐ Yes ☐ No

Please complete the section that is age appropriate for your child.

Infants 0-12 months and Toddlers 1-3 years:

(Y)	(N)		(Y)	(N)		(Y)	(N)	
____	____	Recent Fevers	____	____	Heart Murmur	____	____	Colic/Reflux
____	____	Change in Activity	____	____	Cardiac Problem	____	____	Vomiting
____	____	Weight Difficulties	____	____	Asthma/RAD	____	____	Diarrhea
____	____	Nasal Congestion	____	____	Snoring	____	____	Decreased Appetite
____	____	Runny Nose	____	____	Cough	____	____	Frequent UTIs
____	____	Mouth Breathing	____	____	Cyanosis (blue skin)	____	____	Yeast Infection
____	____	Oral Thrush (yeast)	____	____	Seizure Activity	____	____	Growth Disturbance
____	____	Hearing Concerns	____	____	Development Delay	____	____	Rashes
____	____	Speech Concerns	____	____	Easy Bruising	____	____	Glasses
____	____	Unusual Head Shape	____	____	Easy Bleeding	____	____	Eye discharge/Puffy eyes
			____	____	Allergies Suspected	____	____	Discoloration around eyes

Pre-School 4-6 years, School Aged 7-13 years and Adolescent 14-17 years**:**

(Y)	(N)		(Y)	(N)		(Y)	(N)	
____	____	Recent Fevers	____	____	Snoring	____	____	Growth Disturbance
____	____	Change in Activity	____	____	Cough	____	____	Excessive Fatigue
____	____	Weight Difficulties	____	____	Witnessed Apnea	____	____	Limb Deformity
____	____	Nasal Congestion	____	____	Seizure Activity	____	____	Scoliosis
____	____	Sore Throat	____	____	Development Delay	____	____	Joint/Muscle Aches
____	____	Runny Nose	____	____	Easy Bruising	____	____	Wheelchair Bound
____	____	Mouth Breathing	____	____	Easy Bleeding	____	____	Rashes
____	____	Hearing Concerns	____	____	Allergies Suspected	____	____	Eczema
____	____	Speech Concerns	____	____	Reflux	____	____	Glasses
____	____	Headaches	____	____	Vomiting	____	____	Eye discharge/Puffy eyes
____	____	Heart Murmur	____	____	Diarrhea	____	____	Discoloration around eyes
____	____	Cardiac Problem	____	____	Decreased Appetite	____	____	Bed Wetting
____	____	Asthma/RAD	____	____	Frequent UTIs	____	____	ADD/ADHD