



PEDIATRIC MEDICAL HISTORY FORM

Patient History Form

Name:	Date of Birth:	E-mail Address:
PCP:	Date of Visit	

Race Ethnicity:	<input type="checkbox"/> White, Non-Hispanic <input type="checkbox"/> Black, Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian and Other Pacific Islander <input type="checkbox"/> Other:
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PAST MEDICAL HISTORY

Birth Hospital:	Pregnancy Problems?	<input type="checkbox"/> N	<input type="checkbox"/> Y	Problem in the nursery	<input type="checkbox"/> N	<input type="checkbox"/> Y
Birth Weight:	Labor/delivery Prob?	<input type="checkbox"/> N	<input type="checkbox"/> Y	Baby home with Mom	<input type="checkbox"/> N	<input type="checkbox"/> Y
Discharge Weight:	---- with Mother	<input type="checkbox"/> N	<input type="checkbox"/> Y	Breast Fed?	<input type="checkbox"/> N	<input type="checkbox"/> Y
Discharge Date:	---- with Baby	<input type="checkbox"/> N	<input type="checkbox"/> Y	How Long?		
Hepatitis B Vaccine given in Hospital?		<input type="checkbox"/> N	<input type="checkbox"/> Y			
Pregnancy Duration:						
Problems in first few months?						
Chronic illnesses/injuries?						
Hospitalizations/Surgeries?						
Behavior Issues?						
School Issues?						
Interests/ Activities:						
Location of previous pediatric care:						

Allergic to any medications?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	List
Adverse reaction to medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	List
Allergic to any foods?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	List
Other allergies?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	List

MEDICATIONS

List all medications you currently take including prescription medications, over-the-counter medications and herbal remedies

SOCIAL HISTORY

Mother's First Name:	Age:	Occupation:
Father's First Name:	Age:	Occupation"
Parents Married? <input type="checkbox"/> Yes <input type="checkbox"/> No		Parents living together? <input type="checkbox"/> Yes <input type="checkbox"/> No
Child's Daytime caregiver?		
Others living in your home?		
Siblings names, gender and ages:		

FAMILY HISTORY

(mother, father siblings, grandparents, aunts, uncles and cousins)

Problem	Relationship	Maternal/ Paternal	Problem	Relationship	Maternal/ Paternal
<input type="checkbox"/> ADD		<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Eczema		<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Alcohol Abuse		<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Heart Disease		<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Allergy		<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> High BP		<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Asthma		<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Kidney		<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Birth Defects		<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Mental Illness		<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Cancer		<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Obesity		<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Skin Cancer		<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> School Problems		<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Cholesterol High		<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Seizures		<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Development		<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Stomach/Bowel		<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Diabetes		<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Thyroid		<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Drug Abuse		<input type="checkbox"/> M <input type="checkbox"/> P			

Any other medical condition that "runs in the family"?

DEVELOPMENT/ BEHAVIOR

Problems with eating?	<input type="checkbox"/> N <input type="checkbox"/> Y	Problems in School?	<input type="checkbox"/> N <input type="checkbox"/> Y
Problems with sleeping?	<input type="checkbox"/> N <input type="checkbox"/> Y	Problems with peers/siblings?	<input type="checkbox"/> N <input type="checkbox"/> Y
Problems with elimination?	<input type="checkbox"/> N <input type="checkbox"/> Y	Problems with toilet training?	<input type="checkbox"/> N <input type="checkbox"/> Y
Problems with temper?	<input type="checkbox"/> N <input type="checkbox"/> Y	Problems with behavior?	<input type="checkbox"/> N <input type="checkbox"/> Y
At what age did your child sit alone?		At what age did your child speak words?	
At what age did your child walk?			
Do you have any concerns about your child's development?			

SAFETY/ ENVIRONMENT

Does your child always wear a seat belt?	<input type="checkbox"/> N <input type="checkbox"/> Y	Are there any smokers in the house?	<input type="checkbox"/> N <input type="checkbox"/> Y
Does your child always wear a helmet?	<input type="checkbox"/> N <input type="checkbox"/> Y	Does your home contain lead paint?	<input type="checkbox"/> N <input type="checkbox"/> Y
Do you have working smoke detectors	<input type="checkbox"/> N <input type="checkbox"/> Y	Do you have firearms in the house?	<input type="checkbox"/> N <input type="checkbox"/> Y
Do you have a carbon monoxide detector?	<input type="checkbox"/> N <input type="checkbox"/> Y	If yes, is ammunitions stored separately?	<input type="checkbox"/> N <input type="checkbox"/> Y

TUBERCULOSIS SCREEN

Has your child lived with or spent time with anyone who was positive for tuberculosis?	<input type="checkbox"/> N <input type="checkbox"/> Y
Has your child lived or spent time with anyone who has a positive skin test for tuberculosis?	<input type="checkbox"/> N <input type="checkbox"/> Y
Has anyone in your household come to the United States from another country?	<input type="checkbox"/> N <input type="checkbox"/> Y
Has your child lived with or spent time with adults who were homeless, lived in a shelter?	<input type="checkbox"/> N <input type="checkbox"/> Y
Has your child lived with or spent time with adults who have AIDS or are infected with HIV	<input type="checkbox"/> N <input type="checkbox"/> Y
Has your child lived with or spent time with adults who used intravenous drugs or street drugs?	<input type="checkbox"/> N <input type="checkbox"/> Y
Has your child lived with or spent time with adults who lived in a correctional facility, nursing home, or	<input type="checkbox"/> N <input type="checkbox"/> Y
If you child has had a positive skin test for tuberculosis in the past, inform your child's health care	

OTHER ISSUES YOU WOULD LIKE TO DISCUSS WITH PHYSICIAN

PLEASE PROVIDE A COPY OF YOUR CHILD'S IMMUNIZATION RECORD

Thank you for helping us take better care of your child.

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