



Patient Medical History Form- Pediatric

NAME: _____ AGE: _____ DATE: _____

PHYSICIAN your child was seeing previously: _____

CURRENT MEDICAL PROBLEMS: _____

List all CURRENT PRESCRIPTION MEDICINES (include dosage, reason for taking it, who prescribed it):

List all OVER-THE-COUNTER MEDICINES, vitamins, and food supplements that you take: _____

ALLERGIES to medications or food (including reaction): _____

List SURGERIES (include year, surgeon, and hospital): _____

Describe HOSPITALIZATIONS/ILLNESSES not included above (include year, hospital): _____

List any FRACTURES OR BROKEN BONES including the bone injured and the year: _____

Has your child had (circle):	feeding problems	jaundice	asthma	anemia
bleeding problems	blood clots	head injury	acid reflux	colic
constipation	major infections	seizures	pneumonia	eczema
strep throat	heart murmur	lead poisoning	seasonal allergies	chicken pox
lactose intolerance	depression	mental illness	hearing trouble	vision trouble
mono	ear infections, how many _____		other	_____

Immunizations (check one): up to date _____ delayed _____ I have elected not to immunize my child _____

BIRTH HISTORY

Pregnancy or birth complications? _____ Full term or preterm? _____ Twins? _____

How many weeks/months? _____ Type of Delivery (vaginal/ caesarean) _____ Birth weight? _____

Breast fed or bottle fed (circle one), until what age? _____



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Who in your family has/had (circle if cause of death and write age of death)

heart disease _____	genetic disorder _____
diabetes _____	cancer _____
thyroid disease _____	high blood pressure _____
mental illness _____	arthritis _____
glaucoma _____	asthma _____
allergies _____	tuberculosis _____
seizures _____	substance abuse/addiction _____

List any other diseases that run in your family and specify your relationship to each family member listed. _____

Who lives in your household? _____

Who is the primary caregiver for your child most days? _____ Who else watches your child? _____

Does your child go to (check all that apply)? daycare _____ preschool _____ school _____ home school _____

Do you have any concerns about the safety of your child? _____

Approximately how many hours per day does your child spend watching T.V. or the computer? _____

Does your child wear (circle one) seat belt car seat none Are there guns/firearms in the home? _____

Does your child ride a bicycle? _____ If yes, does he or she wear a helmet? _____

Does your child wear sunscreen? _____ Do you own a swimming pool? _____ pool fence or alarm? _____

Do you have any concerns about your child's diet. _____

Do you have any concerns about your child's weight? _____

Do you have any concerns about your child's breathing? _____

Do you have any concerns about your child's toileting? _____

Do you have any concerns with your child's school performance or ability to learn? _____

Do you have any concerns with your child's behavior? _____

Anything else you would like us to know? _____

Please sign and date: _____