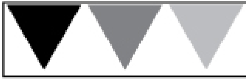

PEDIATRIC MEDICAL HISTORY

PLEASE PRINT THIS INFORMATION BECOMES PART OF YOUR CONFIDENTIAL MEDICAL RECORD **PLEASE PRINT**

Patient's Name
Last First MI

Age ______ Today's Date ______

Date of Birth ______

Previous Physician: (for child)

Mother's Name: Last First MI

Father's Name: Last First MI

Marital Status:

Mother's occupation: Father's occupation:

PATIENT PAST MEDICAL HISTORY (GIVE DATES and DESCRIPTIONS, REASONS, CURRENT STATUS OF ILLNESS)

(Please list dates & reasons)
PREVIOUS SURGERY,
HOSPITALIZATIONS,
MAJOR ILLNESS,
FRACTURES

FAMILY HISTORY	YEAR OF BIRTH	AGE AT DEATH	PRESENT CONDITION OR CAUSE OF DEATH
FATHER			
MOTHER			
BROTHERS NUMBER			
SISTERS NUMBER			
MATERNAL GRANDPARENTS			
PATERNAL GRANDPARENTS			
OTHER			

CHECK IF ANY RELATIVES HAVE HAD	IF CHECKED, WHO (Relation to patient)
□ DIABETES	
□ HEART TROUBLE	
□ HEART ATTACK	
□ HIGH BLOOD PRESSURE	
□ STROKE	
□ CANCER	
□ TUBERCULOSIS	
□ ULCERS	
□ HIGH CHOLESTEROL	
□ OBESITY (OVER WEIGHT)	
□ SUICIDE	
□ EMOTIONAL PROBLEMS	
□ THYROID TROUBLE	
□ ALCOHOL PROBLEMS	
□ LEARNING DISABILITY	
□ ALLERGIES	
□ CONVULSIONS	
□ ASTHMA	
□ HISTORY OF CHILD ABUSE	
□ OTHER	

PREVENTION

Does anyone in the house smoke? □ Yes □ No
If yes, Who?
Do they smoke indoors? □ Yes □ No

Does the child's home have smoke alarms? (check all that apply)
□ In Bedroom □ In hallway outside bedroom
□ In living area □ On every floor
□ No smoke alarms in the home

SEATBELTS:
When in car, does child use car seat or seat belt?
□ Never □ Most of the Time □ Sometimes □ Always
When in car, do parents wear seatbelts?
□ Never □ Most of the Time □ Sometimes □ Always

Are there any guns in the home? □ Yes □ No
If yes, are they stored in a locked cabinet? □ Yes □ No

SCHOOL

Does your child attend (check all that apply)
□ School (K or above) □ Preschool
□ Day Care Center □ Baby Sitter

If in school, does child have any (check all that apply)
□ Special Needs □ Behavioral Problems
□ Academic Problems □ Special Ed. Classes

Has your child ever had any of the following preventive exams?
Dental Exam? □ Yes □ No If yes, when was last exam?
Vision Check? □ Yes □ No If yes, when was last exam?
Hearing Test? □ Yes □ No If yes, when was last exam?

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

DRUG NAME	DOSE	DRUG NAME	DOSE

SPECIFY ANY DRUG REACTION OR ALLERGY: