Pediatric Medical History Update (0-12 years)

Patient's Name: _____ Date of Birth_____

Person completing form_____ Relationship to patient_____

Reason for visit today_____

List all medicines, vitamins, and over the counter medicine patient takes currently:_____

_____

New allergies to medicine or food_____

What kind of milk does child drink (whole, skim, soy, etc.) _____ Cups per day_____

If child drinks juice, how many ounces per day_____ Servings of fruit per day_____

Servings of vegetables per day_____ If child eats meat, servings per day_____

Concerns about eating habits? _____

Number of hours child sleeps at night_____ Naps? How many and how long? _____

Nightmares, night terrors, difficulty sleeping? _____

If child goes to dentist, how often? _____ Dental problems? _____

How many hours per day does your child watch TV? _____ Computer? _____ Video games _____

Cell phone _____

Any updates to family history? Please indicate which family member has had the following since your child's last visit: Alcohol or drug abuse _____ Cancer _____ Kidney disease _____

Heart disease _____ Diabetes _____ Stroke _____ ADHD or ADD _____

High blood pressure _____ Stroke _____ Seizures _____ Thyroid problem _____

Psychiatric problem _____ Asthma or eczema _____ Other_____

Who lives in household with child?

Name Age Relationship to child

_____

_____

_____

_____

_____

_____

Are parents of child married? _____ Separated? _____ Divorced? _____ Who has custody of child? _____

Mother's occupation _____ Father's occupation _____

Child care situation _____

Any concerns about violence in the home? _____ Guns in home? _____ If so, are they safely stored? _____

Name of preschool or school, if any _____ Grade? _____

Concerns about school performance? _____

Concerns about school behavior? _____

Concerns about relationships with teachers? _____ Peers? _____

Does child play sport or do regular exercise? _____Which type? _____

How many days a week? _____ for how long? _____

Does child ride a bike? _____ If so, does child wear a bike helmet? _____ Is child in a safety seat? _____ Booster seat? _____ Seat belt? _____

Using sunscreen when appropriate? _____ Any smokers in the house or car? _____

Does your child have any of the following?

Fever, chills, excessive sweating _____ Unexplained lumps _____

Unexplained weight loss or gain _____ Easy bruising, bleeding _____

Vision problem, squint, crossed eyes _____ Headaches _____

Hay fever, allergies, itchy eyes _____ Weakness, clumsiness _____

Mouth breathing, snoring _____ Muscle or joint pain _____

Speech problems _____ Hearing problem _____

Sleep problems _____ Rash, unusual moles _____

Runny nose, cough _____ Anxiety, stress, depression _____

Other concerns _____

_____

Parent/Guardian signature _____Date _____

Physician/Provider review _____ Date _____