Complete Pediatric Medical History (0-12 yrs)

Patient's Name _____ **Sex**_____ **Date of Birth**_____

Person Completing form _____Relationship to patient_____

Reason for visit today _____

List all medicines/vitamins/over the counter medicines that patient takes currently _____

_____

Hospitalizations and dates _____

Surgery and dates _____

Injuries and dates _____

Chronic illness (asthma, ADHD, anxiety, depression, etc.) _____

_____

Allergies to any medicines or foods _____

Pregnancy: Where was child born? _____

Is the child yours by: birth marriage adoption foster

Any medical problems in pregnancy with this child? _____ If so, what? _____

Any medical problems during newborn phase (0-3 months)? _____ If so, what? _____

Nutrition:

Is/was child breastfed? _____ For how long? _____ Formula fed? _____ For how long? _____

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

What kind of water does child drink (tap, well, bottled)? _____ If child drinks juice, how many cups per day? ____

Servings of fruit per day _____ servings of vegetables per day _____ If child eats meat, servings per day _____

Any concerns about eating habits? _____

Sleep :

How many hours of sleep does child typically get? _____ Naps? _____ How long? _____

Any nightmares/night terrors/difficulty sleeping? _____

Development:

At what age did your child sit alone? _____ Walk? _____ Talk? _____ Toilet train? _____

If girl has started periods, at what age? _____

Dental:

Has child been to dentist? _____ How often? _____ Any dental problems? _____

Infectious Diseases:
Has your child ever had any of the following? If so, when?

Chicken pox _____ Measles _____ Mumps _____

Rubella _____ Meningitis _____ Tuberculosis _____

Exposures/Habits:

Has your child ever been exposed to: **Lead** **Smoke** **Alcohol** **Marijuana** **Abuse**

How many hours per day does your child do the following:

TV _____ **Computer** _____ **Video Games** _____ **Cell phone** _____

Family History: (please indicate which family members have the following conditions)

Alcoholism/drug use: _____ High Blood Pressure: _____

Cancer (any type): _____ Seizures: _____

Kidney Disease: _____ Thyroid Disease: _____

Heart Disease: _____ Psychiatric Disorders: _____

Diabetes: _____ Asthma/Eczema: _____

Stroke: _____ Bleeding/Clotting disorders: _____

ADD/ADHD _____

Social History:
Who lives at home with child? Please give names/ages/relationship to child.

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

What is mother's occupation? _____ Father's occupation? _____

Is violence a concern in the home? _____ Are there guns in the home? _____ If so, are they safely stored? _____

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

Concerns about school performance? _____

Concerns about school behavior? _____

Concerns about relationships with teachers? _____ with 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? _____ Seatbelt? _____ Using sunscreen when appropriate? _____

Any smokers in the house or car? _____

Review of Systems:
Does your child have any of the following:

Fevers/chills/excessive sweating	_____	Headaches	_____
Unexplained weight loss/gain	_____	Weakness/clumsiness	_____
Crossed eyes/squinting/vision issues	_____	Muscle/joint pain	_____
Hay fever/allergies/itchy eyes	_____	Hard of hearing	_____
Mouth breathing/snoring	_____	Skin rashes/unusual moles	_____
Speech problems/sleep problems	_____	Bad breath	_____
Frequent runny nose/gums/teeth issues	_____	Anxiety/stress/depression	_____
Unexplained lumps/easy bruising/bleeding	_____		_____

Any concerns about behavior? _____

Any other concerns? _____

Parent/Guardian Signature_____Date_____

Physician/Provider Reviewed_____Date_____