

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 _____