

## Pediatric Medical and Family History Form

Patient's Name \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Parent's/Guardian's Name: \_\_\_\_\_

Sibling's: \_\_\_\_\_

Allergic Reactions to Medications, food, or vaccines:

\_\_\_\_\_

Medications the patient is currently taking (please include both prescriptions and over the counter):

\_\_\_\_\_

### **Delivery and Birth History**

How was the patient delivered?

Vaginal     C-Section     Adoption     Other

If known, how old was the mother at the time of delivery? \_\_\_\_\_

What was the baby's weight? \_\_\_\_\_ Hospital: \_\_\_\_\_

Did the patient pass the hearing screen?     yes     no

Was the patient breech/feet first?     yes     no

Was the patient premature?     yes     no    How many months? \_\_\_\_\_

Please indicate any medical problems during the baby's newborn period:

\_\_\_\_\_

### **Past Medical History**

Has the patient ever been hospitalized?     yes     no

If yes, when and for what? \_\_\_\_\_

Has the patient ever had surgery?     yes     no

If yes, when and for what? \_\_\_\_\_

Has the patient ever had a serious injury?     yes     no

If yes, when and for what? \_\_\_\_\_

|                                       |   |  |                                       |
|---------------------------------------|---|--|---------------------------------------|
| <input type="checkbox"/> ADD/ADHD     | <input type="checkbox"/> Constipation   | <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> Wheezing     |
| <input type="checkbox"/> Allergies    | <input type="checkbox"/> Depression     | <input type="checkbox"/> Heart Murmur      | <input type="checkbox"/> Other Issues |
| <input type="checkbox"/> Anemia       | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Rashes            |                                       |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Reflux            |                                       |
| <input type="checkbox"/> Autism       | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Seizures          |                                       |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Eczema         | <input type="checkbox"/> Sickle Cell       |                                       |
| <input type="checkbox"/> Chicken Pox  | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Urinary Problems  |                                       |
| <input type="checkbox"/> Concussions  | <input type="checkbox"/> Hearing Loss   | <input type="checkbox"/> Vaccine Reactions |                                       |

Please briefly discuss any other issues or concerns about your child's health below

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Social History**

Who does the patient live with? \_\_\_\_\_

Are Parents \_\_\_\_\_ Married \_\_\_\_\_ Unmarried \_\_\_\_\_ Separated \_\_\_\_\_ Divorced

If not married, custody status: \_\_\_\_\_

Please Circle: Apartment/Townhouse/House \_\_\_\_\_ Age of Home? \_\_\_\_\_ years

Do you have access to a pool? \_\_\_\_\_ yes \_\_\_\_\_ no

Are there any guns in the house? \_\_\_\_\_ yes \_\_\_\_\_ no

Are there any pets in the house? \_\_\_\_\_ yes \_\_\_\_\_ no If yes, what? \_\_\_\_\_

Any foreign travel within the past 5 years? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, where? \_\_\_\_\_

Are there any smokers in the home? \_\_\_\_\_ yes \_\_\_\_\_ no

If so, where do they smoke? \_\_\_\_\_ inside \_\_\_\_\_ outside

Water source: \_\_\_\_\_ City Water or Well Water

Safety Seat (please circle): Rear facing/Forward facing 5 point harness/Booster/Seat Belt

**Family History**

Please state which of the following relatives have the conditions below (if none leave blank):

For grandparent/aunt/uncle please also put M for maternal family or P for paternal family

M=Mother F=Father GM=Grandmother GF=Grandfather B=Brother S=Sister A=Aunt

U=Uncle C=Cousin

\_\_\_\_ ADD/ADHD

\_\_\_\_ Diabetes

\_\_\_\_ Mental Illness

\_\_\_\_ Alcoholism/Drug Abuse

\_\_\_\_ Diarrhea

\_\_\_\_ Migraine/Headaches

\_\_\_\_ Allergies

\_\_\_\_ Ear Infections

\_\_\_\_ Rashes

\_\_\_\_ Anemia

\_\_\_\_ Early Death

\_\_\_\_ Reflux

\_\_\_\_ Asthma

\_\_\_\_ Eczema

\_\_\_\_ Seizures

\_\_\_\_ Autism

\_\_\_\_ Epilepsy

\_\_\_\_ Sickle Cell

\_\_\_\_ Autoimmune Disorder

\_\_\_\_ GI Disease

\_\_\_\_ SIDS (sudden infant death syndrome)

\_\_\_\_ Birth Defects

\_\_\_\_ Hearing Loss

\_\_\_\_ Stoke before 55

\_\_\_\_ Blood Disorders

\_\_\_\_ Heart Murmur

\_\_\_\_ Thyroid Disease

\_\_\_\_ Cancer

\_\_\_\_ High Blood Pressure

\_\_\_\_ Tuberculosis

\_\_\_\_ Constipation

\_\_\_\_ High Cholesterol

\_\_\_\_ Urinary Problems

\_\_\_\_ Cystic Fibrosis

\_\_\_\_ Kidney Disease

\_\_\_\_ Vision Problems

\_\_\_\_ Depression

\_\_\_\_ Liver Disease

Other: \_\_\_\_\_

\_\_\_\_\_