PEDIATRIC MEDICAL HISTORY

(Ages 2 months -12 years)

Patient Name: **DOB:**

Source of information: [ ] Mother [ ] Father [ ] Family member [ ] Another person

MEDICAL HISTORY

List all Allergies (medications/food/environmental) :

No significant Past Medical History [ ]

Please answer all questions that apply to your Child:

Allergic Rhinitis	□ Yes	Diabetes Mellitus	□ Yes
Anemia	□ Yes	Eyesight Problems	□ Yes
Asthma	□ Yes	Fracture	□ Yes
Attention Deficit Disorder (ADD)	□ Yes	Hearing Loss	□ Yes
Attention Deficit Hyperactivity Disorder (ADHD)	□ Yes	Preterm Infant	□ Yes
Blood Disorders	□ Yes	Seizure Disorder	□ Yes
Cancer Type:	□ Yes	Does your child receive special education	□ Yes
Cerebral Palsy	□ Yes	Speech Difficulties	□ Yes
Mental Retardation	□ Yes	Gastric Reflux	□ Yes

Is your child presently taking medication? □ Yes □ No - If yes, please list what medications, strength and for what condition?

HOSPITALIZATION/ SURGICAL HISTORY

Please list below all surgeries and previous hospitalizations? □ Yes □ No - Reason(s) / Date(s)?

SOCIAL HISTORY

Please check all that apply to your Child:

Lives with Parents	□ Yes	Currently in school	□ Yes
Foster Home	□ Yes	Child in Day Care	□ Yes
Group Home	□ Yes	Exposed to cigarette smoke at home	□ Yes
Other: _____	□ Yes	Guns in home	□ Yes

FAMILY HISTORY

Please check (✓) if any of these apply to any of your Child's family member

Family History	Mom	Dad	Siblings	Grandparent
Alcoholism				
Blood Disorders				
Cancer Type:				
Diabetes Mellitus				
Drug Use				
Genetic Disorder				
High Cholesterol				
Hypertension				
Kidney Disease				
Seizure Disorder				
Sickle Cell				
Stroke				
Thyroid Disorders				

Name of Person completing form: _____ Date: _____ 5/28/2015