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Pediatric Medical History (under 18 years old)

This information is collected to better care for you. All records will be kept confidential.

*****Please provide a copy of the patient's immunization records. *****

Name: _____ Preferred Name: _____ Date: _____

Completed by: _____ Relationship to the child: _____

Date of birth: _____ Sex: M F Parents' marital status: _____

Place of birth: _____ Last grade completed: _____

I was referred to practice by: _____ Pharmacy (name/intersection): _____

Members in the patient's household:

Name	Relationship	Age	Occupation/Education

Allergies (medications and other, please specify the reaction): _____

_____

Past medications not tolerated: _____

Medications (include herbs and OTC)	Dose	Diagnosis	How long have you taken it?

Hospitalization/Surgery/Major Illnesses	Where	Year

Born at term? Y N If not, how many weeks gestation? _____

Any complications during pregnancy and/or delivery? _____

Did mom smoke, drink or use drugs during the pregnancy? _____

Jaundice or other problems after birth? _____

Year of last well child exam: _____ dental exam: _____ Do you wear contacts or glasses? _____

Caffeine, tobacco, alcohol or drug use (type, quantity): _____

Exercise (type, frequency): _____ Hours of Sleep: _____

Special diet: _____ Foreign travel in the last 6 months: _____

Name: _____ Date of Birth: _____

Family History (including parents, siblings, children, grandparents, aunts and uncles):

Heart attack at less than 60 years old: _____

Diabetes: _____

Cancer (type): _____

Other (e.g. asthma, allergies, anemia, seizures, mental impairment, kidney problems): _____

_____

Deceased family members including siblings (list age and cause): _____

Symptoms: (circle if applicable)

Weight gain or loss
Increased thirst
Fainting or black outs
Seizures
Frequent falls
Dizziness
Weakness or fatigue
Hair loss or changes
Rash or skin changes
Easy bruising or bleeding
Unusual sweating or night sweats
Unusual lumps or bumps
Trouble sleeping
Snoring
Daytime sleepiness
Problems socializing
Anxiety
Depression
Suicidal thoughts
Behavior problems
Cry frequently
Decreased motivation or interest
Poor concentration
Frequent headaches
Eye/vision problems
Ear/hearing problems
Dental/mouth problems
Nasal problems
Sore throats
Hoarseness
Tuberculosis or positive test
Cough
Asthma/wheezing
Shortness of breath
Pneumonia
Chest pain
Irregular of fast heart beat
Trouble swallowing
Heartburn
Stomach problems
Constipation
Diarrhea
Change in stools
Urinary problems
Sexually active
History of STD
Back or neck problems
Swelling
Leg cramps or problems
Joint pain
Numbness or tingling
Tremor or shakiness
Bone fractures