Pediatric Medical History

Patient Name: _____ **Sex:** Male Female

DOB: _____ **Age:** _____ **Height:** _____ **Weight:** _____ **Birth Weight:** _____

Visit Information

Primary Care Physician: _____ Referring Physician: _____

Reason for Visit: _____

Please list any genetic disorders/syndromes: _____

Birth History Adopted

Was the baby born prematurely?	No Yes	If yes, how early?	_____
Did the baby stay in Neonatal Intensive Care (NICU?)	No Yes	If yes, how long?	_____
Was the baby on a ventilator?	No Yes	If yes, how long?	_____
Was there any bleeding in the brain?	No Yes		
Any birth trauma?	Skull Fracture	Cephalohematoma	Brachioplexus Nerve Injury

Developmental History

Is your child toilet trained:	No	Yes If yes, what age?	_____
At what age did your child:	Sit up _____	Stand _____	Walk _____
Developmental delays:	Motor Skills	Speech/Language	Social Interaction
Feeding / diet is normal for age:	Yes No	By Mouth	By Feeding Tube
School performance:	At Grade Level	Below Grade Level	Above Grade Level
	Special Curriculum	Disruptive Behavior	Inability to Concentrate

Past Medical History

Please note all health issues your child is currently experiencing

Heart Disease	Lung Disease	Hydrocephalus	Rheumatic Fever	Endocrine Disorders
Heart Defects	BPD	Craniosynostosis	Blood Disorders	Chromosome Disorders
Heart Murmur	Asthma	Abnormal Head Shape	Liver Disease	HIV/AIDS
Hypertension	Mechanical Ventilation	Abnormally Large Head	Jaundice	Other _____
Stroke	Tracheostomy	Abnormally Small Head	Cancer _____	

Surgical History NONE

Please list all previous surgeries and approximate dates of surgery

Surgery:	Date:	Surgery:	Date:
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___

Medications NONE

Please list all current medications including over-the-counter medications, vitamins, herbal supplements, and prescribed drugs

Medication:	Dose:	Medication:	Dose:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies NONE KNOWN

Known Drug Allergies:

Latex Shellfish Diagnostic Dyes Metal Antibiotics Other _____

Social History

Current living situation: With Parents With Relatives With Legal Guardian Ward of State

Secondhand smoke exposure: No Yes

Substance use in the home: No Yes - Alcohol _____ Drugs _____

History of abuse / neglect: No Yes - Please explain: _____

Family History

Please note health issues affecting mother, father, sister or brother and indicate which family member is affected

Blood Clots		Autoimmune		Birth Defects		Other	
Heart Disease		Stroke/TIA		Blood Disorders		Cancer - Type:	
Respiratory Disorders		Diabetes		Hydrocephalus		Family Member:	
High Blood Pressure		Neurological Disorders				Malignant Hyperthermia	

Review of Systems

Please check all that apply

Constitutional	Weight Loss	Weight Gain	Frequent Fevers	Fatigue
Eyes	Blurred Vision	Double Vision	Vision Loss	Eye Crossing
Ear, Nose & Throat	Hearing Loss	Ringing in the Ear	Sinus Pressure	Sore Throat
	Swollen Glands	Choking	Difficulty Chewing	Difficulty Swallowing
Cardiovascular	Heart Murmur	Palpitations	Leg Swelling	Shortness of Breath
Respiratory	Chronic Cough	Wheezing	Recurrent Bronchitis	Recurrent Pneumonia
Gastrointestinal	Nausea	Vomiting	Abdominal Pain	Constipation
	Diarrhea	Stool Incontinence		
Genitourinary	Pain w/ Urination	Urinary Frequency	Urinary Urgency	Incomplete Voiding
	Catheterization	Urinary Incontinence		
Musculoskeletal	Back Pain	Arm Pain	Leg Pain	Difficulty Walking
	Toe Walking	Joint Swelling	Scoliosis	
Integumentary	Sores	Rashes	Birthmarks	Sacral dimple
	Hair Tuft	Skin Discoloration		
Neurologic	Spasticity	Weakness	Numbness	Poor Arm / Leg Coordination
	Seizures	Balance Difficulty	Headaches	Attention Deficits
Psychological	Depression	Frequent Crying	Irritability	Behavior Issues
Endocrine	Growth Problems	Excessive Thirst	Excessive Urination	
Hematologic	Easy Bleeding	Easy Bruising	Bleeding Disorders	
Immunological	Seasonal / Environmental Allergies		Recurrent Infections	

Other important health information: _____

Signature

Form completed by: _____ **Date:** _____

Relationship to patient: _____