

Today's Date: \_\_\_\_\_



Name: _____
DOB: ____/____/____
MRN: _____ (or place label here)

# Pediatric Medical History

(Ages 0-11)

Please complete this form about your child. You can skip the questions you don't know the answer to. This information will help us give you better care.

Do you need help filling out medical forms?  Yes  No

### How do you learn best?

Reading information  Hearing information  Pictures  Learn by doing (hands on)

### How do you want to get information?

In writing  Tell me  Show me

## MEDICAL HISTORY

### 1. Has your child had an allergic reaction (bad effect) from any of the following?

- No known allergies  Medicines/Drugs (please describe) \_\_\_\_\_
- Latex (rubber gloves)  Eggs  Peanuts  Bee stings  Shellfish
- Other (please describe) \_\_\_\_\_

2. Is your child taking any medicines/drugs (include non-prescription, herbs, fluoride, vitamins, or supplements) daily? ..... YES  NO

If yes – please list:

### 3. Has your child had any of the following health problems or symptoms?

- |  |   |
|--|---|
| <input type="checkbox"/> Allergies (seasonal, hay fever, etc)                          | <input type="checkbox"/> Cavities or tooth pain/injuries  |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Missing or damaged organs (eye, kidney, testicle)                            |
| <input type="checkbox"/> Autoimmune disorder (lupus/juvenile arthritis/celiac disease) | <input type="checkbox"/> Many headaches/migraines   |
| <input type="checkbox"/> Blood disorders (sickle cell/clotting problems)               | <input type="checkbox"/> Head injury, concussion or seizures  |
| <input type="checkbox"/> Cancer: Type _____  | <input type="checkbox"/> Problems since birth (birth defect, down syndrome, autism, genetic disorder) |
| <input type="checkbox"/> Diabetes: (circle one) pre-diabetes, type 1, or type 2        | Type: _____   |
| <input type="checkbox"/> Heart problems (including murmur or high blood pressure)      | <input type="checkbox"/> Developmental delay  |
| <input type="checkbox"/> High cholesterol  | <input type="checkbox"/> Learning disability or special education needs (IEP or 504 plan)             |
| <input type="checkbox"/> Broken bones: where? _____                                    | <input type="checkbox"/> Mental health condition (ADHD, anxiety, depression, etc.)                    |
|  | <input type="checkbox"/> Other _____  |

4. Has your child had any major injuries or been in the hospital overnight? ..... YES  NO

If yes – what surgeries/injuries or why were they in the hospital?

## BIRTH HISTORY

5. What city/country was your child born in? \_\_\_\_\_
6. Was your child born more than one month early? ..... YES  NO
7. Were there problems with the pregnancy or birth?..... YES  NO   
If yes- what?
8. Did the mother smoke, use drugs, or drink alcohol during the pregnancy, including before she knew she was pregnant? ..... YES  NO   
If yes- what?

## FAMILY MEDICAL HISTORY

**Medical problems can run in families. Please check the boxes below to tell us about any health problems your child's family members have had.**

- Mother** (biological): Living?  Yes  No  I don't know  Has no medical problems
- Diabetes (sugar)  Alcohol/Drug abuse  Heart problems
- Stroke/blood clots  High blood pressure  Mental health condition  
(depression, anxiety, ADHD, etc.)
- Cancer: what type? \_\_\_\_\_
- Other \_\_\_\_\_

- Father** (biological): Living?  Yes  No  I don't know  Has no medical problems
- Diabetes (sugar)  Alcohol/Drug abuse  Heart problems
- Stroke/blood clots  High blood pressure  Mental health condition  
(depression, anxiety, ADHD, etc.)
- Cancer: what type? \_\_\_\_\_
- Other \_\_\_\_\_

- Sister/Brothers:** How many? \_\_\_\_\_ Living?  Yes  No  I don't know
- Has no medical problems
- Diabetes (sugar)  Alcohol/Drug abuse  Heart problems
- Stroke/blood clots  High blood pressure  Mental health condition  
(depression, anxiety, ADHD, etc.)
- Cancer: what type? \_\_\_\_\_
- Other \_\_\_\_\_

Signature X \_\_\_\_\_ (Parent/Guardian)

for office use: Provider

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_