

PEDIATRIC MEDICAL HISTORY FORM

Legal Name: _____

Preferred Name: _____

DOB: _____

Adopted: Y N Foster Child: Y N

Grade: _____ **School:** _____

- American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander
 White Hispanic or Latino Not Hispanic or Latino Multiracial (*Required for vaccine administration purposes.*)

Please check if you experience/experienced any of the following:

- | | | | | | |
|---|--|---|---|---|-----------------------------------|
| <input type="checkbox"/> Abuse (Physical/Mental/Sexual) | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Concussion | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Headaches | <input type="checkbox"/> Joint Issues | <input type="checkbox"/> Hearing Issues | <input type="checkbox"/> Heart Murmur | |
| <input type="checkbox"/> Menstrual Issues (Females) | <input type="checkbox"/> Migraines | <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Prematurity | <input type="checkbox"/> Sleep Problems | |
| <input type="checkbox"/> Recurrent Ear Infections | <input type="checkbox"/> Reflux | <input type="checkbox"/> Seizure Disorder | | | |
| <input type="checkbox"/> Urinating Difficulties | <input type="checkbox"/> Other (Please specify): _____ | | | | |

Immunizations up to date? Y N

Please provide vaccination records

List all operations/hospitalizations, including year:

Parent Name(s):

Names & Ages of all people living in the household:

Birth History:

Prenatal complications (i.e. diabetes, hypertension)?

Born: Pre-term Full-term

Complications of delivery?

- Cesarean Shoulder Dystocia NICU

Family History: (Blood Relatives Only)

Family Member	If living, list any health problems. If deceased, list cause of death.	Age?
Father:		
Mother:		
Siblings:		
Paternal Grandparents:		
Maternal Grandparents:		

Family Medical: Have any family members ever had _____?

- | | |
|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Genetic Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Curved Spine | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Sudden Infant Death |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Other: _____ |

Medications: Include over the counter, vitamins, and supplements along with dose taken. Check if no medications.

Medication Allergies or Intolerances:

Safety:

- Y N Smoke alarm in the home?
 Y N Carbon monoxide alarm in the home?
 Y N Firearms in the household?
 Y N Secondhand tobacco smoke?
 Y N Tobacco use in the home?
 Y N Alcohol use in the home?
 Y N Prescription pain meds in the home?
 Y N Marijuana or other drug use in the home?

Females Only:

Current method of Birth Control (if applicable):

Onset of menses/period? Y N Age? _____

Please initial and date any updates made:

_____ (sign/date)

_____ (sign/date)

_____ (sign/date)

PEDIATRIC HISTORY QUESTIONNAIRE

For Children Up to 3 Years Old			
Delivery/Newborn Period:	Birth History: During pregnancy, did mother:		
Delivery Type (circle one): Vaginal C- Section	Smoke?	<input type="radio"/> Y	<input type="radio"/> N
Birth Weight	Drink Alcohol?	<input type="radio"/> Y	<input type="radio"/> N
Problems in Newborn Period:	Use Drugs/Medications?	<input type="radio"/> Y	<input type="radio"/> N
	Experience Illness?	<input type="radio"/> Y	<input type="radio"/> N

For Children Up to 3 to 9 Years Old			
Where does your child go to school?	What grade?		
Has your child repeated or been held back a grade?	<input type="radio"/> Y	<input type="radio"/> N	
Has your child attended a special class?	<input type="radio"/> Y	<input type="radio"/> N	
Does your child have behavior problems in school?	<input type="radio"/> Y	<input type="radio"/> N	
Has your child had any bullying problems?	<input type="radio"/> Y	<input type="radio"/> N	
How much screen time (video, TV, computer, phone) during the typical day?	_____ hours per day		

For Children Up to 10 to 12 Years Old			
Where does your child go to school?	What grade?		
Has your child repeated or been held back a grade?	<input type="radio"/> Y	<input type="radio"/> N	
Has your child attended a special class?	<input type="radio"/> Y	<input type="radio"/> N	
Does your child have behavior problems in school?	<input type="radio"/> Y	<input type="radio"/> N	
Any academic problems?	<input type="radio"/> Y	<input type="radio"/> N	
Has your child had any bullying problems?	<input type="radio"/> Y	<input type="radio"/> N	
Any concerns about body image?	<input type="radio"/> Y	<input type="radio"/> N	
How much screen time (video, TV, computer, phone) during the typical day?	_____ hours per day		
Please explain any Yes answers:			

For Children Up to 13 to 18 Years Old			
Where does your child go to school?	What grade?		
Does your child have behavior problems in school?	<input type="radio"/> Y	<input type="radio"/> N	
Any academic problems?	<input type="radio"/> Y	<input type="radio"/> N	
Has your child had any bullying problems?	<input type="radio"/> Y	<input type="radio"/> N	
Any concerns about body image?	<input type="radio"/> Y	<input type="radio"/> N	
Any concerns about sexuality?	<input type="radio"/> Y	<input type="radio"/> N	
Any concerns for anxiety or depression?	<input type="radio"/> Y	<input type="radio"/> N	
Do you use alcohol?	<input type="radio"/> Y	<input type="radio"/> N	
Do you use tobacco?	<input type="radio"/> Y	<input type="radio"/> N	
Do you use caffeine, tea, soda, or power drinks?	<input type="radio"/> Y	<input type="radio"/> N	
Do you use "recreational drugs"?	<input type="radio"/> Y	<input type="radio"/> N	
Are you sexually active?	<input type="radio"/> Y	<input type="radio"/> N	
If Yes to above, with whom?	<input type="radio"/> Males	<input type="radio"/> Females	<input type="radio"/> Both
Have you ever been abused?	<input type="radio"/> Physically	<input type="radio"/> Mentally	<input type="radio"/> Sexually
Are you satisfied with your weight?	<input type="radio"/> Y	<input type="radio"/> N	
What do you do for exercise?	<input type="radio"/> Y	<input type="radio"/> N	
How often do you exercise?	<input type="radio"/> Y	<input type="radio"/> N	
Do you always wear a seatbelt?	<input type="radio"/> Y	<input type="radio"/> N	
If you ride a bike or motorcycle, do you always wear a helmet?	<input type="radio"/> Y	<input type="radio"/> N	
Are guns kept in your home?	<input type="radio"/> Y	<input type="radio"/> N	
How much screen time (video, TV, computer, phone) during the typical day?	_____ hours per day		