PEDIATRIC MEDICAL HISTORY FORM

Legal Name: ___________________________________

Preferred Name: _________________________________

DOB: ____

Adopted: ☐ Y ☐ N Foster Child: ☐ Y ☐ N

Grade: ______________ **School:** ____________________

Parent Name(s):

Names & Ages of all people living in the household:

☐ 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:

☐ Abuse (Physical/Mental/Sexual) ☐ ADD/ADHD ☐ Allergies ☐ Anemia ☐ Anxiety Disorder ☐ Asthma
☐ Cancer ☐ Chicken Pox ☐ Concussion ☐ Congenital Heart Disease ☐ Depression ☐ Diabetes
☐ Eczema ☐ Headaches ☐ Joint Issues ☐ Hearing Issues ☐ Heart Murmur
☐ Menstrual Issues (Females) ☐ Migraines ☐ Psychiatric Disorder ☐ Prematurity
☐ Recurrent Ear Infections ☐ Reflux ☐ Seizure Disorder ☐ Sleep Problems
☐ Urinating Difficulties ☐ Other(Please specify): ____

Immunizations up to date? ☐ Y ☐ N
Please provide vaccination records

List all operations/hospitalizations, including year:
____
____
____

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:		

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?

Family Medical: Have any family members ever had________?

☐ ADD/ADHD ☐ Eczema
☐ Allergies ☐ Genetic Disorder
☐ Asthma ☐ Heart Problems
☐ Birth Defects ☐ High Cholesterol
☐ Blood Disorder ☐ Learning Disabilities
☐ Cancer ☐ Mental Illness
☐ Curved Spine ☐ Migraines
☐ Deafness ☐ Obesity
☐ Depression ☐ Seizure Disorder
☐ Developmental Delay ☐ Sudden Infant Death
☐ Diabetes ☐ Thyroid Disease
☐ Drug/Alcohol Abuse ☐ Other: _______________

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			
Term(39 wks)/Preterm(37 or <) - Weeks? :	Birth History: During pregnancy, did mother:		
Delivery Type (circle one): Vaginal C- Section	Smoke?	○ Y	○ N
Birth Weight:	Drink Alcohol?	○ Y	○ N
Problems in Newborn Period:	Use Drugs/Medications?	○ Y	○ N
	Experience Illness?	○ Y	○ 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?	○ Y	○ N
Has your child attended a special class?	○ Y	○ N
Does your child have behavior problems in school?	○ Y	○ N
Has your child had any bullying problems?	○ Y	○ 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?	○ Y	○ N
Has your child attended a special class?	○ Y	○ N
Does your child have behavior problems in school?	○ Y	○ N
Any academic problems?	○ Y	○ N
Has your child had any bullying problems?	○ Y	○ N
Any concerns about body image?	○ Y	○ 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?		○ Y	○ N
Any academic problems?		○ Y	○ N
Has your child had any bullying problems?		○ Y	○ N
Any concerns about body image?		○ Y	○ N
Any concerns about sexuality?		○ Y	○ N
Any concerns for anxiety or depression?		○ Y	○ N
Do you use alcohol?		○ Y	○ N
Do you use tobacco?		○ Y	○ N
Do you use caffeine, tea, soda, or power drinks?		○ Y	○ N
Do you use “recreational drugs”?		○ Y	○ N
Are you sexually active?		○ Y	○ N
If Yes to above, with whom?	○ Males	○ Females	○ Both
Have you ever been abused?	○ Physically	○ Mentally	○ Sexually
Are you satisfied with your weight?		○ Y	○ N
What do you do for exercise?		○ Y	○ N
How often do you exercise?		○ Y	○ N
Do you always wear a seatbelt?		○ Y	○ N
If you ride a bike or motorcycle, do you always wear a helmet?		○ Y	○ N
Are guns kept in your home?		○ Y	○ N
How much screen time (video, TV, computer, phone) during the typical day?		__________ hours per day	