Pediatric Medical Health History Form

This form will help your clinician better understand you or your child's medical concerns and conditions. If you are uncomfortable with any question, do not answer it.

Please provide your best guess when a date is requested.

Name: ________________________________Date of Birth: _______________Today's Date: __________________
Name of Person Completing this form: _______________________ Relationship to Patient: ________________
Preferred Provider: ________________________ Preferred Pharmacy: ___________________________

MEDICATIONS *(Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, oxygen, CPAP)*

Medication and Dose	Instructions	Medication and Dose	Instructions

ALLERGIES *(Medicines, Seasonal, Environmental, Foods)*

Allergy	Reaction	Allergy	Reaction

PERSONAL MEDICAL HISTORY

Please list any medical problem(s), hospitalizations, surgeries, serious illnesses, or accidents you have ever had.

History	Date

Please make a check mark next to any of the below developmental concerns.

Concern	Yes	Concern	Yes
Physical Development		School Experience	
Behavior		Bathroom/Toilet Habits	
Eating Habits		Discipline	
Sleeping Habits		Other *	

**Other problems, please specify:* ____
If you have ever had a blood transfusion, please specify date(s) ____
Would a blood transfusion be acceptable in an emergency? ____No ____Yes
Do you have any religious or spiritual beliefs? ____No ____Yes
Last Dental Exam? ________________ Last Eye Exam? ______________

BIRTH HISTORY

Birth Weight: _________ Birth Length: ___________ Place of Birth: ____________________________________
Length of stay at the hospital after birth: ____

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Please make a check mark if the mother experienced any of the following conditions during the pregnancy.

Condition	Yes	Condition	Yes
High Blood Pressure		Alcohol Use	
Diabetes		Substance Use	
Bleeding/Clotting Disorder		Tobacco Use	
Depression		Other *	

**Other problems, please specify:* ____

FAMILY HISTORY

Please list any biological family members that have ever had any of the following conditions.

Condition	Family Member	Condition	Family Member
Alcoholism/Substance Abuse		COPD	
Anemia		Heart disease/Heart attack	
Anxiety		Heart Failure	
Asthma		Heart Valve problems	
Cancer (type)		High blood pressure	
Depression		Kidney disease	
Diabetes (type)		Stroke	
Seizures		Other*	

**Other problems, please specify:* ____

Does the child have consistent child-care (baby-sitter, pre-school, day care)? ____________________________

Please list all people in the household and any siblings (including those that may have passed away).

Name	Relationship	Date of Birth

HEALTH MAINTENANCE

Please enter the date of your most recent immunizations and tests.

Flu _______ Pneumonia ______ Tetanus ________ HPV _________

Hepatitis A _______ Hepatitis B ________ Measles ________ Mumps_______ Rubella_______

MMR ______ Varicella (chicken pox) _______ PPD _______

SOCIAL HISTORY (This section is for teenagers and is to be completed by the patient)

Tobacco/Alcohol/Drug Use

Do you smoke? ____ No ____Yes Current Smoker: ____packs/day ______ # of years

Do you use any of the following? ___ Pipe ___ Cigar ___ Snuff ___ Chew ___ E-cigarettes/Vape

Do you drink alcohol? _____ No ______ Yes, # drinks/week___________

Do you use any street drugs? ____ No ____ Yes, *please specify:* ____________________________

Have you ever used street drugs? ____ No ____ Yes, *please specify:* ____________________________

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Have you ever injected street drugs? _____ No _____ Yes, *please specify:* ______________________________

Diet/Exercise

meat servings per day: ___________ # fresh fruit/vegetable servings per day: ________________

of snacks per day: ________ # sweetened beverages per day: ____ # caffeinated beverages per day: _____

Do you exercise regularly? _____ No _____ Yes, *please specify*: _____________________________________

SOCIOECONOMICS (This section is for teenagers and is to be completed by the patient)

Are you currently employed? ____ No _____ Yes Occupation: _______________________

Education completed: ______________________

Marital status: ____Single ____M ____Sep ____D ____W ____Cohabitating

Spouse/Partner's name: ______________________________________ Number of children: ________

WOMEN'S GYNECOLOGIC HISTORY (This section is for teenagers and should be completed by the patient)

pregnancies: ____ # deliveries: ____ # miscarriages: ____ # abortions: _____ Age at first childbirth: ____

1st day, most recent period: ______ Age at 1st period: ____ Frequency of periods: ______

Length of each period: _____ Do you have any concerns about your periods? ___ No ___ Yes

Ever had an abnormal PAP? ____ No ___ Yes: results ____

SEXUALITY (This section is for teenagers and should be completed by the patient)

Sexually Active: ____ Yes ____ No

Current sex partner(s) is/are: ___ male ___ female

If sexually active, do you practice safe sex (use condoms)? _____ NA ____ No _____ Yes

Have you ever had any sexually transmitted diseases (STDs)? ____ No ____ Yes

If yes, please specify: ____date___________

Are you interested in being screened for sexually transmitted diseases? ____ No ____ Yes

Ever been exposed to HIV/AIDS? _____ No _____ Yes

Have you been tested for HIV? _____ No _____Yes: results _______________

Would you like to be tested for HIV? _____ No _____ Yes

Other concerns? ____

SAFETY (This section is for teenagers and should be completed by the patient)

Do use seatbelts consistently? ___ No ___ Yes

Do you have a smoke detector in your home? ___ No ___ Yes

Is violence at home a concern for you? ____ No ____ Yes

Do you feel safe in your current relationship? ____ N/A ____ No ____ Yes

Do you have a gun in your home? ____ No ____ Yes

Do you use a bike helmet regularly? ___ N/A ____ No ____ Yes

Other concerns? ____

EMOTIONS (This section is for teenagers and should be completed by the patient)

During the past month, have you often been bothered by feeling down, depressed, or hopeless?

____ No ____ Yes

During the past month, have you often been bothered by little interest or pleasure in doing things?

____ No ____ Yes

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REVIEW OF SYSTEMS

Please make a check mark next to any symptoms you have had in the last couple of days:

Constitutional		Respiratory	
Unintended Weight Loss		Cough	
Unintended Weight Gain		Shortness of breath or difficulty breathing	
Poor Appetite		Wheezing	
Fever		Coughing up sputum	
Chills		Coughing up blood	
No Energy		Chest tightness	
Eyes		**Gastrointestinal**	
Pain		Difficulty swallowing	
Blurry vision		Abdominal pain	
Double Vision		Heartburn	
Redness		Nausea	
Itchiness		Vomiting	
Swelling		Diarrhea	
Discharge		Blood in stool	
Ears, Nose, Throat		Mucus in stool	
Ear Pain		Change in bowel habits	
Discharge		Loss of bowel control	
Hearing Loss		**Genitourinary**	
Ringing in the ears		Discharge	
Sinus Pressure		Blood in urine	
Drooling		Pain with urination	
Facial Swelling		Increased frequency or urgency	
Sore Throat		Urinary loss of control	
Mouth Lesions		Flank pain	
Dental Pain		Testicular pain or swelling	
Swollen Glands		Redness	
Cardiovascular		Itchiness	
Swelling		Masses/lumps	
Chest Pain		**Musculoskeletal**	
Shortness of breath with activity		Soft tissue swelling	
Heart Palpitations (heart racing or fluttering)		Muscle pain	
Breasts		Moves arms and legs well	
Lumps		Localized joint pain	
Tenderness		Previous injuries	
Discharge		Spine pain	
		Pain radiating down arms	
		Pain radiating down legs	
		Weakness in arms	
		Weakness in legs	

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Skin		Female Health	
Pain		Irregular Menses	
Itching		Non-menstrual Bleeding	
Dryness/Flaking		Menopausal Symptoms	
Redness		Hot Flashes	
Rash/Hives		Night Sweats	
Growths/Lumps		Dry Vaginal Mucosa	
Swelling		Change in Libido (sex drive)	
Bruising		Orgasmic Dysfunction	
Insect Bites		Difficult or Painful Intercourse	
Lesions		Vaginal Tightening	
Neuro		**Male Health**	
Numbness		Change in Libido	
Weakness		Difficulty with Intercourse	
Tingling		Impotence	
Burning		**Allergic/Immunologic**	
Shooting Pain		Seasonal Allergies	
Headache		Sneezing	
Dizziness		Runny Nose	
Trouble finding words or forgetting words		Food Allergy	
Speech Difficulties		Contact Dermatitis (allergic skin rash)	
Poor Coordination			
Loss of Consciousness			
Arm or hand weakness			
Difficulty Emptying Bladder			
Change in Bowel Habits			
Psychiatric			
Decreased Functioning Ability			
Depression			
Anxiety			
Insomnia			
Stress			
Loss of Interest			

Please feel free to make any additional comments for any symptoms you are experiencing or any concerns you may have and would like to discuss at your initial appointment:

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