

## PEDIATRIC MEDICAL HISTORY

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

REASON FOR TODAY'S VISIT: \_\_\_\_\_

PREVIOUS TREATMENT FOR THIS PROBLEM: \_\_\_\_\_

### HAVE YOU EVER HAD THE FOLLOWING? (check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> High Blood Pressure                             | <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Kidney disease     |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Stroke                         | <input type="checkbox"/> Hepatitis          |
| <input type="checkbox"/> Heart attack / arterial disease                 | <input type="checkbox"/> Heartburn/reflux/hiatal hernia | <input type="checkbox"/> HIV                |
| <input type="checkbox"/> Other heart issue: _____                        | <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Problems with anesthesia                        | <input type="checkbox"/> Thyroid problems               | <input type="checkbox"/> Cholesterol issues |
| <input type="checkbox"/> Bleeding problems                               | <input type="checkbox"/> Sleep apnea                    | <input type="checkbox"/> Lung problems/COPD |
| <input type="checkbox"/> Cancer(s), type(s) and date of diagnosis: _____ |   |   |
| <input type="checkbox"/> NONE OF THE ABOVE                               |   |   |

### LIST ALL OTHER PAST & CURRENT MEDICAL ISSUES

_____	_____	_____
_____	_____	_____
_____	_____	_____

### LIST ALL SURGERIES AND DATES

_____	_____	_____
_____	_____	_____
_____	_____	_____

### LIST ALL CURRENT MEDICATIONS AND DOSES (include supplements and any over-the-counter medications)

_____	_____	_____
_____	_____	_____
_____	_____	_____

### LIST ALL DRUG ALLERGIES AND REACTIONS ☐ NO KNOWN DRUG ALLERGIES

_____	_____	_____
_____	_____	_____

### SOCIAL HISTORY

Born full term ☐ Yes ☐ No | Premature # weeks \_\_\_\_\_ | Pregnancy Complications: \_\_\_\_\_ | Birth Complications: \_\_\_\_\_

Newborn hearing screen: ☐ Passed ☐ Failed | Vaccinations up to date? ☐ Yes ☐ No

Lives with parents? ☐ Yes ☐ No | ☐ Daycare ☐ School ☐ Home Schooled ☐ Foster Care

Exposure to Second Hand Smoke? ☐ Yes ☐ No

### FAMILY MEDICAL HISTORY

Any family history with life-threatening reaction to anesthesia? \_\_\_\_\_

MOTHER: ☐ Alive | Died age: \_\_\_\_\_ Significant Medical Problems: \_\_\_\_\_

FATHER: ☐ Alive | Died age: \_\_\_\_\_ Significant Medical Problems: \_\_\_\_\_

SIBLINGS: \_\_\_\_\_ #sisters / \_\_\_\_\_ #brothers Significant Medical Problems: \_\_\_\_\_

### ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? (check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Fever               | <input type="checkbox"/> Rash                   |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Seizures               |
| <input type="checkbox"/> Wheezing            | <input type="checkbox"/> Decreased energy level |
| <input type="checkbox"/> Vomiting            | <input type="checkbox"/> Excessive urination    |
| <input type="checkbox"/> Blood in urine      | <input type="checkbox"/> Abnormal bleeding      |
| <input type="checkbox"/> Limb weakness       |   |
| <input type="checkbox"/> NONE OF THE ABOVE   |   |