Pediatric Patient History Form

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We are currently using an electronic medical record system for the documentation of all patient visits. If you are a new patient to our office, or if you are a patient we have not seen in awhile, we are asking that you please complete the follow form so we may enter your child's medical history into the system. Please be as detailed as possible when answering the questions. All information will be kept strictly confidential in compliance with federal HIPPA regulations.

Patient's Name: ____________________________________ **Age:** _______ **Gender:** ____ **Date:** ________________

List primary reason for coming to the Doctor:

____

List ALL of your child's medications:

____

____

Patient/Family History: Please place a check if your child or family member has ever had problems with any of the following:

	Patient	Family		Patient	Family		Patient	Family
Anemia:	_____	_____	ADHD/ADD:	_____	_____	Autism:	_____	_____
Bleeding Problems:	_____	_____	Birth Defects:	_____	_____	Cancer:	_____	_____
Cerebral Palsy:	_____	_____	Diabetes:	_____	_____	Down Syndrome:	_____	_____
Genetic Disease:	_____	_____	Headaches:	_____	_____	Heart Problems:	_____	_____
Hearing Loss:	_____	_____	High Blood Pressure:	_____	_____	High Cholesterol:	_____	_____
Infertility:	_____	_____	Kidney Problems:	_____	_____	Liver Function:	_____	_____
Lung Problems:	_____	_____	Psychiatric:	_____	_____	Seizures:	_____	_____
Substance Abuse:	_____	_____	Thyroid:	_____	_____	Tuberculosis:	_____	_____
Urinary Tract:	_____	_____	Other:	_____	_____			

Explain positive responses: ____

____

____

<u>MORE ON BACK SIDE</u>

Past Medical History:

Infections: ______________________________

Behavior Problems: ______________________________

Surgeries: ______________________________

Hospitalizations: ______________________________

Other: ______________________________

Birth & Development:

Full Term? Yes [ ] No [ ]

Birth Weight: ______________

Delivery: Vaginal [ ] C-Section [ ]

Birth Complications: ______________________________

Family & Social History

Smoking exposure at home? Yes [ ] No [ ]

Day Care? Yes [ ] No [ ]

Siblings (how many)? __________

Pets (what kind)? ______________________________

Other Concerns:

Does your child have any sleep concerns?
Yes [ ] No [ ]

Does your child have any stress concerns?
Yes [ ] No [ ]

Weight Issues? Yes [ ] No [ ]

Does your child follow a special diet?
Yes [ ] No [ ]

Please list all people who live in the home and their relationship to your child: ______________________________

____

____

Have you seen or consulted specialists, or other health care providers? Yes [ ] No [ ]

From Completed by: ______________________________ Relationship to Patient: ______________________

Please provide us with a copy of your child's immunization records.

FOR OFFICE USE ONLY

☐ Scanned Date received: ______________