Reset Form

Traverse Area Pediatric and Adolescent Clinic

PEDIATRIC MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____/_____/_____

Parent/Guardian Signature: _____ Date: _____/_____/_____

Date of Last Well Visit:_____ Date of Last Sick Visit:_____

PERSONAL MEDICAL HISTORY: *Please indicate whether the patient has had any of the following medical problems.*

- ☐ Asthma/Wheezing
- ☐ Anemia
- ☐ Lung Disease
- ☐ Anxiety or Depression
- ☐ Hearing Problems
- ☐ Heart Disease
- ☐ Ear Infections - Recurrent
- ☐ Convulsions/Epilepsy
- ☐ Constipation
- ☐ ADHD
- ☐ Vision Problems
- ☐ Seasonal Allegies

Other:_____

_____

_____

MEDICATIONS: *Please list all prescription and non-prescription medications, vitamins, home remedies, birth control, herbs etc.*

Medication Name	Dose	Frequency

ALLERGIES: *List all reactions to medicines, foods and other agents.*

Allergy	Reaction or Side Affect

***** If you child is taking any medications - please bring the bottle or a photo of each bottle to first appointment *****

HOSPITALIZATONS: *Please list all prior hospitalizations and dates.*

Reason	Date

Surgeries: *Please list all prior surgeries and dates.*

Reason	Date

COMMUNICABLE DISEASES:

Has the patient ever had any of the following communicable disease(s)?

☐ Chickenpox ☐ Measles ☐ Mumps ☐ Rubella ☐ Meningitis ☐ Tuberculosis (TB)

PREGNANCY & BIRTH:

Is the patient yours by: □Birth □Adoption □Fostercare □Other: _____

Were there any medical problems during pregnancy? □ Yes □ No If yes, please explain: _____

Were there are problems during labor and delivery? □ Yes □ No If yes, please explain: _____

Did the patient have any problems such as needing oxygen, trouble breathing, jaundice (yellowness), etc. after the patient's birth? □ Yes □ No

If yes, please explain: _____

Where was the patient born? _____ Method of Delivery: □Vaginal □ Caesarean

Birth Weight/Length: ___lbs. ___oz. ___inches Was your child born prematurely? □ Yes □ No If yes how early: _____

Did your child spend any time in the NICU? □ Yes □ No If yes how long: _____

For Male Patients Only: Is your child circumcised? □ Yes □ No

SLEEP:

How many hours a night does the patient sleep? _____ How many naps does the patient take per day and length of naps? _____
Does the patient have any sleep problems? □ Yes □ No If yes, please explain: _____

NUTRITION & FEEDING:

Type of feeding when the patient was a newborn: □Breastfed □Formula. If breastfed, for how long? _____
Has the patient had any feeding/dietary problems or restrictions? □ Yes □ No If yes, please explain: _____
_____
_____

Milk intake now: □ Soy Milk □ Rice Milk □ Cow's Milk (____ %) □ other, please specify: _____, # of ounces per day _____
Has the patient seen a dentist? □ Yes □ No If yes, date of last visit _____. What is the water source at the house? □ City □ Well

DEVELOPMENT:

At what age did the patient: Sit Alone _____ Walk Alone _____ Say Words _____ Toilet Train (Daytime) _____
Were there any concerns about growth or progress made in such areas as rolling over, walking, riding a tricycle, dressing themself, or feeding themself? □ Yes □ No If yes, please explain: _____
Are there any area of concerns about language or speech development? □ Yes □ No If yes, please explain: _____
When the patient is in the car, do they use? □ Infant Seat □ Booster Seat □ Seatbelt Only
Does the patient wear a helmet while riding a bike? □ Yes □ No
Do you have concerns about the patient's behavior at home or in groups with other children? □ Yes □ No
If yes, please explain: _____

For Menstruating Patients Only: Age at first menstrual period _____ First day of last period:_____

SOCIAL HISTORY:

Are the patient's parents: □ Married □ Never Married □ Separated □ Divorced If divorced, for how long? _____
Parent 1 Employer: _____ Occupation: _____
Parent 2 Employer: _____ Occupation: _____
Stepparent 1 Employer: _____ Occupation: _____
Stepparent 2 Employer: _____ Occupation: _____
Guardian Employer: _____ Occupation: _____

Do any household members smoke? □ Yes □ No Is violence in the home a concern? □ Yes □ No Are there guns in the home? □ Yes □ No
Is there any concerns regarding this patient's: □ Alcohol Use □ Vaping □ Tobacco Use □ Sexual Activity □ Aggressive Behavior
How many hours per day does the patient spend with the following: ___Watching TV ___On the Computer/iPad ___Playing Video Games
Do you have any concerns about lead exposure due to having an old home, or because of plumbing, and peeling paint? □ Yes □ No
Do you have smoke detectors in your home? □ Yes □ No
Who else lives at home with the patient?

Name	Age	Relationship	Highest Level of Education

SCHOOL HISTORY:

Did/Does the patient attend school/preschool? □ Yes □ No Current grade in school? _____
Do you have concerns with how the patient is doing in school? □ Yes □ No
Any concerns about relationships with teachers or other students? □ Yes □ No
If more than 4 years old: does your child have a good friend? □ Yes □ No
Does your child play any sports? □ Yes □ No How many times a week? _____ How long (minutes) _____
Is your child involved in any extracurricular activities? □ Yes □ No If yes what activity: _____

FAMILY HISTORY: *Please indicate with a check* (√) *who in the patient's family has had the following conditions. In the first column please indicate their living status. L = Living, D = Deceased, U = Unknown.*

	Living Status	Asthma	Diabetes	High Blood Pressure	Heart Disease before 50	ADHD	Anxiety	Cancer (Type)	Substance Abuse	Depression	Other
Biological Mother											
Biological Father											
Biological Siblings											
Maternal Grandmother											
Maternal Grandfather											
Paternal Grandmother											
Paternal Grandfather											
Other Family Members Information: *(please write in)*											

REVIEW OF SYSTEMS: *Please indicate with a check* (√) *any current problems your child has on the list below.*

CONSTITUTIONAL
- ☐ Fevers/chills/sweats
- ☐ Unexplained weight loss
- ☐ Fatigue/weakness
- ☐ Excessive thirst or urination

CARDIOVASCULAR
- ☐ Chest pain/discomfort
- ☐ Leg pain with exercise
- ☐ Palpitations

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Blood in bowel movement
- ☐ Nausea/vomiting/diarrhea

NEUROLOGICAL
- ☐ Headaches
- ☐ Dizziness/light-headedness
- ☐ Numbness
- ☐ Memory loss
- ☐ Loss of coordination

EYES
- ☐ Change in vision
- ☐ Nearsighted
- ☐ Farsighted

CHEST (BREAST)
- ☐ Breast lump/discharge

GENITOURINARY
- ☐ Nighttime urination
- ☐ Incontinence
- ☐ Sexual function problems
- ☐ Discharge from penis

GYNECOLOGICAL
- ☐ Abnormal vaginal bleeding
- ☐ Problems with conception
- ☐ Problems with contraception
- ☐ Vaginal discharge
- ☐ Vaginal odor
- ☐ Painful intercourse

EARS/NOSE/THROAT/MOUTH
- ☐ Difficulty hearing/ringing in
- ☐ Hay fever/allergies
- ☐ Problems with teeth/gums

RESPIRATORY
- ☐ Cough/wheeze
- ☐ Difficulty breathing

MUSCULO-SKELETAL
- ☐ Muscle/joint pain

SKIN
- ☐ Rash or mole change(s)

PSYCHIATRIC
- ☐ Anxiety/stress
- ☐ Problems with sleep
- ☐ Depression

OTHER: _____

_____