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 * Please Specify	Depression	Other
Biological Mother											
Biological Father											
Biological Siblings * Please Specify											
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: _____

_____