Pediatric Medical History Form

Please complete the following form on behalf of the child coming to the appointment. The information contained herein is strictly confidential and will not be released unless you authorize us to do so.

CHILD'S NAME: _____ DATE OF BIRTH: _____
LAST *FIRST* *MI*

PARENT/GUARDIAN #1 NAME: _____
RELATIONSHIP TO CHILD (circle one): MOTHER / FATHER / GRANDPARENT / STEP-PARENT / OTHER_____
ADDRESS: _____ CITY, STATE, ZIP:_____
PRIMARY PHONE: _____ TYPE (circle one): CELL / HOME EMAIL: _____
OCCUPATION:_____ EMPLOYER: _____ WORK PHONE: _____

PARENT/GUARDIAN #2 NAME: _____
RELATIONSHIP TO CHILD (circle one): MOTHER / FATHER / GRANDPARENT / STEP-PARENT / OTHER_____
ADDRESS: _____ CITY, STATE, ZIP:_____
PRIMARY PHONE: _____ TYPE (circle one): CELL / HOME EMAIL: _____
OCCUPATION:_____ EMPLOYER: _____ WORK PHONE: _____

PRIMARY CARE PROVIDER (PCP): _____ PHONE #: _____
REFERRING PROVIDER (if different than PCP): _____ PHONE #: _____

BIOLOGICAL FAMILY HISTORY

	Sex	Age	Health Problems
Child's Mother	M F	____	_____
Child's Father	M F	____	_____
Child's Brothers/Sisters	M F	____	_____
	M F	____	_____
	M F	____	_____
	M F	____	_____

Does the child have any family members with the following health problems? *(include aunts, uncles, grandparents, etc.)*
Crohn's Disease/Ulcerative Colitis/IBD: _____Gallbladder Problems: _____
Celiac Disease: _____ Irritable Bowel Syndrome: _____
Bleeding Disorders: _____ Kidney/Bladder Problems: _____
Anemia: _____ Jaundice: _____
Cancer of Colon/Rectum: _____ Pancreas/Liver Problems/Hepatitis: _____
Constipation: _____ Stomach/Duodenal Problems: _____
Food Allergies: _____

SOCIAL HISTORY

List everyone who lives in the child's home(s) _____
Are there smokers in the home? YES NO
Is the child up to date with immunizations? YES NO
Has the child been out of the United States within the last six (6) months? YES NO

MEDICATIONS

List all medications that the child is currently taking, prescription and over the counter.

Medication	Daily Dose	How Often

ALLERGIES

List the medications, injections, or substances (including LATEX) that have given the child a bad reaction. If possible, include the reaction (rash, hives, difficulty breathing, etc.)

Name	Type of Reaction	Year

PAST HISTORY

Surgery/Overnight Hospitalizations	Year	Hospital	Physician

List any medical problem not requiring hospitalization (asthma, cardiac problems, chronic ear infections, etc.).

Problem	Year	Treatment	Physician

Does the child have any developmental delays? YES NO

If yes, please explain: _____

INFANT HISTORY/FEEDING SCHEDULE *(Please complete only if child is under 1 year of age)*

Child's birth weight _____ lbs., _____ oz. Birth (circle one): Cesarian / Vaginal

At how many weeks was the child was born (30 weeks, 40 weeks, etc.): _____

Is the child breast or formula fed? _____

If formula fed, please answer the following questions:

How many ounces does the child take at each feeding? _____ How often does the child eat? _____

Which formula does the child use? _____ What other formulas has the child tried?_____

If breast fed, please answer the following questions:

How long does the child nurse on each side? _____ How often does the child nurse? _____

Does the child frequently spit up? _____

Please list anything else the child eats/drinks in a normal day: _____

_____

_____

Has the child had any NICU or extended hospital stays? _____

Please circle yes or no if the child has now or recently had the following:

SYSTEMIC REVIEW

YES	NO	Chills/Fever	YES	NO	Weight Loss	YES	NO	Bruises Easily
YES	NO	Vision Problems	YES	NO	Change in Activity Level	YES	NO	Convulsions/Seizures
YES	NO	Uncontrolled Movements	YES	NO	Recent Passing Out	YES	NO	Headache
YES	NO	Skin Rashes	YES	NO	Difficulty Breathing While Being Fed			

RESPIRATORY & CARDIOVASCULAR

YES	NO	Recent Hoarseness	YES	NO	Irregular Heartbeat	YES	NO	Chronic Cough
YES	NO	Heart Murmur	YES	NO	Asthma or Wheezing	YES	NO	History of rheumatic fever
YES	NO	Exposure to Tuberculosis	YES	NO	Turning Blue	YES	NO	Waking Up Short of Breath

GASTROINTESTINAL

YES	NO	Does any food give child trouble	YES	NO	Blood on toilet paper/diaper
YES	NO	Bloated after eating	YES	NO	Trouble drinking milk
YES	NO	Difficulty or painful swallowing	YES	NO	Vomiting
YES	NO	Vomiting blood	YES	NO	Diarrhea/Loose stools
YES	NO	Constipated more than twice a month	YES	NO	Pain when moving bowels
YES	NO	Bowel Movements bloody or black	YES	NO	Bleeding from rectum
YES	NO	Had an X-Ray of stomach or colon	YES	NO	Had a Procto/Colonoscopy
YES	NO	Had an Upper Endoscopy	YES	NO	Had Hepatitis
YES	NO	Abdominal blood tests of liver/pancreas	YES	NO	Choking or feeding difficulties
YES	NO	Other: _____			

How often does the child have a bowel movement? _____
At what age was the child toilet trained? _____

If already toilet trained, or currently working on it, please answer the following questions:

YES NO Any streaking or soiling of bowel movement in underwear? If yes, how often does this happen? _____
YES NO Does your child have difficulty controlling his/her bowel movement?
YES NO Do you think your child is attempting to "hold in" his/her bowel movements?

GENITOURINARY

YES	NO	Burning or pain with urination	YES	NO	Bloody or brown urine
YES	NO	Any kidney stones	YES	NO	Other: _____

PRESENT PROBLEM(S)

Use the space below to describe the child's symptoms or the reason for scheduled visit.

_____
_____
_____

Who can we thank for this referral? _____

_____ _____
Signature of Patient's Guardian *Date*

_____ _____
Signature of Physician Reviewing Form *Date*

Updated 11.13.24