MEDICAL HISTORY

DATE:_____

Patient's Name:_____ Date Of Birth:_____
Reason for Visit:_____
Pediatrician/Primary Care Physician:_____

BIRTH HISTORY: NEW PATIENTS ONLY
Length of Pregnancy: _____Weeks Birth Weight: _____ Birth Length: _____
Vaginal or C-Section Delivery _____ Number of Days in Hospital _____
Complications during pregnancy or delivery? _____

MEDICAL HISTORY: (List all prior hospitalizations, surgical procedures, and serious illnesses)

☐ Please check box if no changes since last visit.

_____
_____
_____
_____
_____

MEDICATIONS: Please list ALL current medications including prescription and over the counter medications.

_____
_____
_____
_____

ALLERGIES: Please list any allergies to medications and the type of reactions.

_____

VACCINATIONS: Up to date? YES or NO (circle one)

FAMILY HISTORY (Mark all that apply or select "none" below): Please list the family member's relationship to the patient.

☐ Please check box if no changes since last visit.

- o Babies born with heart disease or children who had heart surgeries: _____
- o Sudden or unexplained deaths in a child, teenager, or young adult: _____
- o Heart attack in someone before 50 years of age:_____
- o Pacemaker placement in a child, teenager or young adult:_____
- o Abnormal heart rhythms:_____
- o Hypertrophic Cardiomyopathy:_____
- o Hypertension:_____
- o Syndromes such as Wolff-Parkinson-White, Long QT syndrome, Romano-Ward, Williams syndrome, Marfan syndrome or DiGeorge syndrome: _____
- o Congenital deafness:_____
- o Diabetes:_____
- o High Cholesterol:_____
- o Asthma:_____
- o None

SOCIAL HISTORY:
What grade is your child in?
Who does the patient live with? (Please circle all that apply)
MOM DAD SISTER BROTHER GRANDPARENTS OTHER

SMOKING: Passive Smoke Exposure? YES or NO (circle one)

Does your child have a history of (circle all that apply or select "none" below): If patient is an Infant or Toddler please answer additional questions.

GENERAL ○ None ○ Appetite Change ○ Activity Change ○ Fever ○ Irritability ○ Lethargy (lack of energy) ○ Trouble Sleeping	*Infant/Toddler* ○ Fatigues Easily ○ Poor Sleeper ○ Excessive Crying ○ Slow Weight Gain	**CARDIAC** ○ None ○ Chest pain ○ Cool Extremities ○ Color Change ○ Easy Fatigability ○ Excessive Sweating ○ Syncope (Fainting) ○ Fast Heartbeat ○ Irregular Heartbeat ○ Palpitations ○ Murmur	
RESPIRATORY ○ None ○ Asthma Symptoms ○ Chronic Cough ○ Recurrent Wheezing ○ Frequent Pneumonia ○ Shortness of breath with Exercise ○ Snoring	*Infant/Toddler* ○ Fast Breathing	**MUSCULOSKELETAL/SKIN** ○ None ○ Bone Deformity ○ Joint Pain ○ Joint Swelling ○ Muscle Aches ○ Birthmarks ○ Cyanosis (bluish color) ○ Rash ○ Nail changes	*Infant/Toddler* ○ Swelling hands/feet ○ Muscle Weakness ○ Decreased Muscle Tone ○ Hemangiomas ○ Signs of eczema
EYES, EARS, NOSE, THROAT ○ None ○ Blurred Vision ○ Use corrective lenses ○ Gum Bleeding ○ Hearing Loss ○ Nasal Congestion ○ Nosebleeds ○ Sleep Apnea ○ Tooth Pain	*Infant/Toddler* ○ Lazy Eye ○ Eye Drainage ○ Eye Redness ○ Hearing Problems ○ Nosebleeds ○ Nasal Drainage ○ Noisy Breathing ○ Teething	**GASTROINTESTINAL/ GENITOURINARY** ○ None ○ Abdominal Pain ○ Abdominal Distention ○ Eating Problems ○ Reflux ○ Nausea ○ Vomiting ○ Blood in Urine ○ Decreased Urination ○ Frequent Urination	*Infant/Toddler* ○ Diarrhea ○ Constipation ○ Blood in Stool ○ Coughing or Choking with Feeds ○ Feeding Problems ○ Colic ○ Jaundice ○ Foul Odor in Urine
NEUROLOGICAL ○ None ○ Seizures ○ Frequent headaches ○ Dizziness	*Infant/Toddler* ○ Extreme Irritability ○ Unusual Movements ○ Stopping Breathing ○ Hyperactivity	**HEMATOLOGIC** ○ None ○ Easy bruising ○ Bleeding Problems ○ Swollen Glands	
ENDOCRINE ○ None ○ Excessive Weight Gain ○ Slow Growth ○ Weight Loss	*Infant/Toddler* ○ Abnormal Growth	**PSYCHIATRIC** ○ None ○ ADD ○ ADHD ○ Depression ○ School Problems	

_____ _____

Signature of Parent/Guardian Date