

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.
- Babies born with heart disease or children who had heart surgeries: _____
 - Sudden or unexplained deaths in a child, teenager, or young adult: _____
 - Heart attack in someone before 50 years of age: _____
 - Pacemaker placement in a child, teenager or young adult: _____
 - Abnormal heart rhythms: _____
 - Hypertrophic Cardiomyopathy: _____
 - Hypertension: _____
 - Syndromes such as Wolff-Parkinson-White, Long QT syndrome, Romano-Ward, Williams syndrome, Marfan syndrome or DiGeorge syndrome: _____
 - Congenital deafness: _____
 - Diabetes: _____
 - High Cholesterol: _____
 - Asthma: _____
 - 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.

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

Signature of Parent/Guardian

Date