Patient Name: _____ DOB: _____

PATIENT MEDICAL HISTORY

Past Medical History if less than 8 years old:

Mother's Length of Pregnancy: _____ weeks or months (circle one)

Problems during Pregnancy? YES NO (circle one)

Birth Weight: _____

Length of hospitalization after birth: _____

Immunizations up to date? YES NO (circle one)

Previous Hospitalizations? YES NO (circle one) If yes, list: _____

Previous Surgeries? YES NO (circle one) If yes, list: _____

Allergies? (Circle all that apply)

Medicine YES NO (circle one) If yes, list: _____

Seasonal YES NO (circle one) If yes, list: _____

Foods YES NO (circle one) If yes, list: _____

Any Developmental Problems? YES NO (circle one) If yes, list: _____

Family History: (Mark all that apply and tell us if the family member is on the paternal or maternal side.)

History of:	***Family Member:***	***History of:***	***Family Member:***
Born with Heart Defects	Maternal or Paternal?	High Blood Pressure	Maternal or Paternal?
High Cholesterol	Maternal or Paternal?	Sudden Death	Maternal or Paternal?
Heart Attacks/Stroke less than 55yrs	Maternal or Paternal?	Diabetes	Maternal or Paternal?
Heart Rhythm Problems/Pacemakers	Maternal or Paternal?	Seizures	Maternal or Paternal?

Social History:

Patient lives with: Mother Father Stepmother Stepfather (circle all that apply)

_____ brothers _____ sisters Other _____

School: _____ grade

Please list any medications the patient is currently taking:

_____

_____

_____

_____

(continued on back)

Review of Systems: (fill in the circle for all that apply)

General	❍ Appetite Change ❍ Trouble Sleeping	❍ Activity Change	❍ Fever	❍ Irritability	❍ Lethargy
Eyes	❍ Blurred vision	❍ Corrective Lenses			
Ears, Nose & Throat	❍ Gum Bleeding ❍ Tooth Pain	❍ Hearing Loss	❍ Nasal Congestion	❍Nosebleeds	❍ Sleep Apnea
Cardiovascular	❍ Chest Pain	❍ Cool Extremities	❍ Color Change	❍ Easy Fatiguability	❍ Excessive Sweating
	❍ Fainting	❍ Fast Heartbeat	❍ Irregular Heartbeat	❍ Murmur	❍ Palpitations
Respiratory	❍ Asthma Symptoms	❍ Chronic Cough	❍ Recurrent Wheezing	❍ Shortness of Breath with Exercise	❍ Snoring
GI	❍ Abdominal Distension	❍ Abdominal Pain	❍ Eating Problems	❍ Reflux Symptoms	❍ Nausea ❍ Vomiting
GU	❍ Blood in Urine	❍ Decreased Urination	❍ Frequent Urination	❍ Kidney Stones	
Musculo-skeletal	❍ Bone Deformity	❍ Joint Pain	❍ Joint Swelling	❍ Muscle Aches	❍ Scoliosis
Skin	❍ Birthmarks	❍ Cyanosis	❍ Rash	❍ Nail Changes	
Neurological	❍ Dizziness	❍ Headache	❍ Seizures	❍ Weakness	❍ Tremors
Endocrine	❍ Excessive Weight Gain	❍ Slow Growth ❍ Change in Periods	❍ Weight Loss	❍ Diabetes	❍ Thyroid Problems
Hematologic	❍ Bleeding Problems	❍ Easy Bruising	❍ Swollen Glands		
Psychiatric	❍ ADD	❍ ADHD	❍ Depression	❍ School Problems	❍ Behavior Problems