PEDIATRIC PATIENT MEDICAL HISTORY FORM

(please complete both sides – attach additional form if needed)

Date	Child's Name	Preferred name/Nickname	DOB

Primary Care Physician (PCP)	PCP Phone Number	Date of Last Well Child Exam

Mother's Full Name	Father's Full Name
Custodial provider (If different from above)	Relationship to Patient
Does the child have an eye doctor? ☐ No ☐ Yes (if yes, please provide name and date of last exam)	Does the child have a dentist? ☐ No ☐ Yes (if yes, please provide name and date of last appointment)

Preferred Pharmacy Name, Address, phone number

With whom does the child live (list all household members and their relationship to child):

Does anyone smoke in or outside the home? ☐ No ☐ Yes

Is this child currently or has he/she ever been in foster care? ☐ No ☐ Yes, currently (specify age child entered foster care ________________)
☐ Yes, in the past (specify ages in foster care ______________________)

Birth and Development History

Birth weight________
Pregnancy #________
Mom's age at delivery ________
Type of birth:
☐ Vaginal ☐ Cesarean (reason _______________________________)
☐ Term ☐ Premature (how many weeks early _______________)

Did mom have any illnesses/problems during pregnancy?
☐ No ☐ Yes (if yes, please explain____________________________)

Before mom knew she was pregnant or anytime during her pregnancy, did she use:
- ☐ Cigarettes (how many per day? _____________________)
- ☐ Alcohol (drinks per week? ________________________)
- ☐ Any other substance/drug, prescribed or not, to get "high" (type and how often? _______________________________)

Did your child have any problems during or after birth?
☐ No ☐ Yes (if yes, please explain ____________________________
____)

Did your child have any developmental delays? ☐ No ☐ Yes
(if yes, please explain ____
____)

Does your child receive any services at school for a developmental, behavioral, or medical diagnosis such as a 504 or Individualized Education Plan (IEP)? ☐ No ☐ Yes
(if yes, please explain ____
____)

Does your child see any medical specialists? ☐ No ☐ Yes
(if yes, please explain ____
____)

Medical History

List current medications your child is taking (attach additional page if necessary):

Medication Name	Dosage	Time of Day Taken	Prescribers Name

List any allergies your child has to foods or medications: ____
____

Has your child received all the recommended vaccinations recommended for their age? ☐ Yes ☐ No (if no, why? ______________________
____)

Medical History (Continued from previous page)

List any surgeries your child has had and the year they had the surgery: ______________________________
____

List any medical illnesses your child has (asthma, diabetes, seizures, migraines, etc.): ______________________
____

List any mental health diagnoses your child has and who is providing treatment (therapists, physicians, APRNs, counselors, etc.):
____
____

List any surgeries or overnight hospitalizations your child has had: ______________________________
____

Family Medical History (Parents, Siblings, Grandparents, Aunts and Uncles)

Have Any Family Members Had the Following:

Condition	Y	N	Details
Alcohol/Drug Abuse	□ Y	□ N	Details:
Allergies	□ Y	□ N	Details:
Asthma	□ Y	□ N	Details:
Birth Defects	□ Y	□ N	Details:
Blood Disorders	□ Y	□ N	Details:
Bone Disorders	□ Y	□ N	Details:
Cancer	□ Y	□ N	Details:
Diabetes	□ Y	□ N	Details:
Endocrine Disease	□ Y	□ N	Details:
Ear/Nose/Throat Disorders	□ Y	□ N	Details:
Eye Disorders	□ Y	□ N	Details:
Gastrointestinal Disorders	□ Y	□ N	Details:
Heart Disease	□ Y	□ N	Details:
High Blood Pressure	□ Y	□ N	Details:
High Cholesterol	□ Y	□ N	Details:
Immune Disorders	□ Y	□ N	Details:
Joint Problems	□ Y	□ N	Details:
Kidney Disease	□ Y	□ N	Details:
Liver Disease	□ Y	□ N	Details:
Lung Disease	□ Y	□ N	Details:
Migraine Headaches	□ Y	□ N	Details:
Metabolic Disorders	□ Y	□ N	Details:
Obesity	□ Y	□ N	Details:
Seizure Disorders	□ Y	□ N	Details:
Skin Disorders	□ Y	□ N	Details:
Stroke History	□ Y	□ N	Details:
Thyroid Disorders	□ Y	□ N	Details:
Mental Health History	□ Y	□ N	Details:
Other Medical History	□ Y	□ N	Details:
Other Medical History	□ Y	□ N	Details:

Please list any other pertinent information to your child's medical history for the medical provider: ____________________
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____
____
____
____