Pediatric Medical History Form

Legal Name: _____ DOB: _____ Date: _____

Preferred Name: _____ Pronoun(s): _____ Gender: _____

Who lives in the child's household?
Any other adults involved in the child's care?
List allergies/intolerances to medications:

Personal Medical History: Circle Yes or No, explain yes answers (when occurred or was diagnosed)		
Alcoholism	Y	N
Anxiety Disorder	Y	N
Anemia	Y	N
Arthritis	Y	N
Asthma	Y	N
Bleeding tendency	Y	N
Blood clot	Y	N
Cholesterol (high)	Y	N
Cancer	Y	N
Depression	Y	N
Diabetes	Y	N
Emphysema/COPD	Y	N
Epilepsy	Y	N
Exposure to asbestos	Y	N
Exposure to TB	Y	N
Glaucoma	Y	N
Hayfever	Y	N
Heart disease	Y	N
Hepatitis (yellow jaundice)	Y	N
High blood pressure	Y	N
Kidney disease	Y	N
Kidney stone	Y	N
Migraines	Y	N
Osteoporosis	Y	N
Pneumonia	Y	N
Polio	Y	N
Recurrent bladder infection	Y	N
Rheumatic fever	Y	N
Sleep Apnea	Y	N
Stroke	Y	N
Thyroid disease	Y	N
Tuberculosis	Y	N
Ulcer	Y	N
Other serious illness	Y	N

Please list all surgeries with dates.	
Surgery	Date:

Adopted?	Y	N
Foster Child?	Y	N

Family History (Blood Relatives)		
If living, list any health problems (heart disease, cancer, diabetes, high blood pressure, etc.). If deceased, cause of death.		**Age at Death**
Father		
Mother		
Maternal Grandparents		
1		
2		
Paternal Grandparents		
1		
2		
Brothers and Sisters		
1		
2		
3		
4		
5		

Family Medical: Place a check next to each condition a family member has had.					
ADD/ADHD			Eczema		
Allergies			Genetic Disorder		
Anemia			Heart Problems		
Asthma			High Cholesterol		
Birth Defects			High Blood Pressure		
Blood Disorder			Learning Disability		
Cancer			Mental Illness		
Curved Spine			Intellectual Disability		
Deafness			Migraines		
Depression			Obesity		
Developmental Delay			Seizure Disorder		
Diabetes			Sudden Infant Death		
Drug/alcohol abuse			Thyroid Disease		
Other:					

Safety		
Is there a smoke alarm in the home?	Y	N
Carbon monoxide alarm in the home?	Y	N
Guns in the household?	Y	N
Secondhand tobacco smoke?	Y	N
Prescription pain meds in the home?	Y	N
Marijuana or other drug use in the home?	Y	N

Meds		
Any daily over-the-counter medications?	Y	N
If Yes, which ones?		
1		
2		
3		
4		

FORM CONTINUES ON THE OTHER SIDE

PEDIATRIC HISTORY QUESTIONNAIRE

For children up to 3 years old

Delivery/Newborn Period:	**Birth History: During pregnancy, did mother**		
Delivery Type (circle): Vaginal C-Section	Smoke?	Y	N
Birth Weight:	Drink alcohol?	Y	N
Problems in Newborn Period:	Use Drugs/Medications?	Y	N
	Experience illness?	Y	N
Please explain any YES answers:			

For children 3 to 9 years old

Where does your child go to school?	What grade?		
Has your child repeated or been held back a grade?		Y	N
Has your child attended a special class?		Y	N
Does your child have behavior problems at school?		Y	N
Has your child had any bullying problems?		Y	N
How much screen time (video, TV, computer, phone) during a typical day?	Hours per day:		
Please explain any YES answers:			

For children 10 to 12 years old

Where does your child go to school?	What grade?		
Has your child repeated or been held back a grade?		Y	N
Has your child attended a special class?		Y	N
Does your child have behavior problems in school?		Y	N
Has your child had any bullying problems?		Y	N
Any academic problems?		Y	N
How much screen time (video, TV, computer, phone) during a typical day?	Hours per day:		
Any concerns about body image?		Y	N
Please explain any YES answers:			

For children 13 to 18 years old (Patient to Complete)

Where do you go to school?	What grade?				
Do you have behavior problems in school?				Y	N
Have you had any bullying problems?				Y	N
Any academic problems?				Y	N
How much screen time (video, TV, computer, phone) during a typical day?	Hours per day:				
Any concerns about body image?				Y	N
Concerns about sexuality?				Y	N
Do you use alcohol?				Y	N
Do you use tobacco?				Y	N
Do you use caffeine, coffee, tea, soda, power drinks?				Y	N
Do you use "recreational drugs"?				Y	N
Are you sexually active?	Yes	Not Currently		Never Have	
What gender(s) are you attracted to?				Not Sure	
Would you like to talk about sexual health topics or gender identity today?				Y	N
Do you see a dentist?				Y	N
If yes, list dentist name:					
Any concerns for depression or anxiety?				Y	N
Have you ever been abused?	No	Physically	Mentally	Sexually	
Are you satisfied with your weight?				Y	N
What do you do for exercise?					
How often do you exercise?					
Do you always wear a seat belt?				Y	N
If you ride a bike or motorcycle, do you always wear a helmet?				Y	N
Are guns kept in your home?				Y	N
If yes, is the household aware of gun safety?				Y	N
Please explain any YES answers					

Practitioner: _____ Date: _____

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