Associates in Family Medicine

Patient History Form (Pediatric to Age 12)

Patient Name__________________________________ **DOB**___________________ **Today's Date**___________

Mother's name________________________________ **Father's name**_________________________________

Home phone__________________________ **Alternate phone**_______________________________________

Who lives in your household?____

Are they in good health?____

MEDICAL HISTORY

Please list any current or past illnesses your child has been treated for:

____

____

____

Please list any medications your child is currently taking and bring them with you to your appointment. Please include strength and frequency.

Medication	Strength (mg.)	Frequency

Does your child have any medication allergies? Yes No
Please list name of drug and type of reaction:

Does your child have a latex allergy? Yes No

IMMUNIZATION HISTORY:

Are immunizations up-to-date? Yes No
Has your child ever had a serious reaction to an immunization? Yes No (If yes, explain in space below)
Do you have immunization records? Yes No (If so, please have them sent to us or bring them to the appointment)

(CONTINUED)

Please list surgical procedures your child has had in the past:

____

Does your child currently or has he/she ever done the following (check all that apply):

____ Smoke. If so, how much per day?____

____Use smokeless tobacco. If yes, how many times per day?________________________________

____Drink alcohol. If yes, how many drinks per day?______________________________________

____Use recreational drugs or prescription drugs that were prescribed for someone else? If yes, how many times per week and what type?____

____ Does anyone in the household/caregiver's household: ___smoke ___drink alcohol ___use recreational drugs

____ Pets in the household/caregiver's household?_______________________________________

____Exercise regularly? If yes, how many times per week?__________________________________

____Wear seat belts or use a car or booster seat regularly.

____Wear safety helmets.

Please list all physicians your child has seen in the past 5 years:

__________________________ ___________________________ _____________________________

Does your child have problems with (check all that apply):

____Difficulty with vision
____Crossed eyes
____Eye infections
____Difficulty hearing
____Frequent ear infections
____Frequent colds
____Frequent sore throats
____Mouth breathing
____Snoring
____Hoarseness
____Difficulty swallowing
____Birth defects

____Problems with teeth
____Shortness of breath
____Frequent cough
____Wheezing
____Swelling
____Fainting
____Heart racing
____Nausea/vomiting
____Diarrhea
____Rashes/hives
____Blood in urine
____Heart murmur

____Constipation
____Bowel habit change
____Rectal bleeding
____Abdominal pain
____Bed wetting
____Headaches
____Seizures
____Joint pain
____Muscle pain or cramps
____Muscle weakness
____Excessive thirst
____Menstrual periods

___Dizziness
___Overly anxious
___Weight gain
___Weight loss
___Fatigue
___ Cry easily
___Bullying
___Often depressed
___Sexual concerns
___Developmental delay
___Hyperactivity
___Learing disability

(CONTINUED)

FAMILY HEALTH HISTORY

(Please check the box where child's BLOOD relatives have any of these problems)

	FATHER	MOTHER	Grandfather		Grandmother		BROTHER	SISTER	MOTHER'S SIDE	FATHER'S SIDE
			Maternal	Paternal	Maternal	Paternal				
Allergies (asthma, exzema, hay fever)										
Birth defects (cleft lip, Down's syndrome)										
Blood/ bleeding disorders, sickle cell anemia										
Bone/joint disorders (arthritis, hip disorders)										
Cancer (leukemia, breast cancer, other tumors)										
Diabetes, thyroid disorders										
Eye/ear disorders (deafness, blindness)										
Heart disease (heart attack, high blood pressure)										
Kidney disease (cystic kidneys, absent kidney)										
Lung disorders (cystic fibrosis, tuberculosis)										
Muscle disorders (Multiple Sclerosis, Muscular Distrophy)										
Neurologic disorders (migraine headaches, seizures, epilepsy)										
Psychiatric disorders (suicide, depression, anxiety)										
Sexually transmitted diseases (syphilis, gonor-rhea, herpes, chlamydia)										
Alcoholism, drug dependency, HIV/AIDS										
Other										

The following information is of value in the complete evaluation of your child. Answering is optional and confidential.

School: ___Cyber ___Private ___Public Daycare: ___Home ___Elsewhere

PLEASE CIRCLE LEVEL OF EDUCATION:

	High School	Vocational School	College	Graduate School
Mother…………………………………	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Father …………………………………	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4

Thank you for choosing Associates in Family Medicine and completing this important health history form. This information will help your doctor provide the best care for your child.

2/2016