New Pediatric Patient Medical History Form

Age:_______
Patient Name:____________________________Today's Date ____/____/____ Who referred you? ___________________________________
Why is your child here today? ____
When did the problem/symptoms start: ____
Please describe the problem in detail:____
____
____
____

Past Medical and Surgical History

Please check any condition or illness you have had:
[] Asthma [] Allergies [] Attention Deficit Disorder [] Diabetes [] Pneumonia [] Speech Delay
[] Heart Abnormalities [] Gastric Reflux [] Bleeding Problems [] Seizures [] Croup [] Developmental Delay
[] Autism [] Ear Infections
Please name any other medical problems not listed above:____
____
Any surgeries: [] No [] Yes If yes, list surgeries and dates:____
____
Has your child ever experienced problems with anesthesia? [] No [] Yes. If yes, describe:______________________________
____
Prior Hospitalizations: [] No [] Yes If yes, list reason for hospitalization and dates: ______________________________
____

Birth History

Check all that apply: [] Premature [] Neonatal Breathing Problems [] NICU [] Intubation [] Jaundice
Passed Infant Hearing Test? [] Yes [] No
Please describe any problems above: ____
____
Birth Weight:____
Feeding Problems? ____

Medication History

Please list ANY prescription or over-the-counter/herbal medications currently being taken : [] None
____
____
____
____
____
Is your child ALLERGIC to any medication? [] No [] Yes If yes, please list below and type of reaction:
____
____
____
Please circle if your child is allergic to any of the following: Latex Shellfish Iodine Bee Stings Gluten Eggs Peanuts

Allergy History

Does your child have environmental allergies or sensitivities to pollens, dust, food, bees, etc? [] No [] Yes
If yes, indicate what your child is allergic to and the type of reaction: ____
____
Has your child ever had a skin or blood allergy test? [] No [] Yes If yes, indicate the year, test type, and results:______________
____
Has your child ever taken allergy shots? [] No [] Yes If yes, indicate the year (s) and if they were helpful: ___________________
____

Family Medical History

Please list any 1st or 2nd degree relatives of your child who has any of the following:
Serious illnesses or cancer:____
Hearing loss or ear disease:____
Anesthesia adverse reactions:____
Bleeding/clotting disorder:____
Other:____

Review of Systems
Please circle any symptoms that your child is currently having

General	Fever	Tired	Sweating	Weight Change	
Eyes	Loss of vision	Blurry Vision	Tearing	Pain	Double Vision
Ears	Ringing	Discharge	Hearing Loss	Pain	Dizziness
	Itching	Infection			
Nose	Congestion	Obstruction	Pressure	Pain	Runny Nose
	Post-nasal drainage	Sneezing	Bleeding	Loss of Smell	
Throat	Snoring or Sleep Apnea	Loss of Taste	Sores	Pain	Growth
	Difficulty Swallowing	Difficulty Chewing	Hoarseness	Tonsillitis	Bad Breath
Neck	Mass or Lump			Pain	
Cardiovascular	Irregular Heart beat	Chest Pain	Palpitations		
Pulmonary	Shortness of breath	Dry Cough	Productive Cough	Wheezing	
Gastrointestinal	Heartburn	Indigestion	Nausea or Vomiting	Pain	Diarrhea/ Constipation
Musculoskeletal	Arthritis	Joint Pain	Muscle Aches		
Neurologic	Headaches	Tingling	Numbness		
Psychiatric	Depression	Memory Loss	Confusion	Anxiety	
Endocrine	Hyper-activity	Fatigue	Excessive Thirst	Heat Intolerance	Cold Intolerance
Renal	Trouble Urinating	Excessive Urination			

Please list anything else you think is important to your child's visit today:

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____
____
____

I certify that the information provided on this medical history is correct and complete.

Parent or guardian signature: _______________________________ Date: ________________