

## CHILD MEDICAL HISTORY TO AGE 12

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

What is the chief concern about your child today? \_\_\_\_\_

**MEDICATIONS:** List all prescription and over the counter medications that your child is currently taking regularly. Include vitamins, herbs and other supplements and how your child takes them. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<p><b>ALLERGIES:</b> Medications your child is allergic to or has reactions to:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>List any non-medication allergies:</p> <p>_____</p>	<p><b>IMMUNIZATIONS:</b> Please bring copy of child's immunization record to the visit, or indicate where immunization records are maintained.</p>
---	--

**RISK FACTORS:**

- |  |  |
|--|--|
| <p> <input type="checkbox"/> Yes <input type="checkbox"/> No Passive smoke exposure</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No Uses tobacco, alcohol or street drugs</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No Gets hurt if someone in family gets angry</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Pets in the home</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Home was built after 1950</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Wears helmet for biking, skating, skiing, riding</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Working smoke detector in the home</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Gets regular exercise</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Uses sun screen</p> | <p><input type="checkbox"/> Yes <input type="checkbox"/> No Parents know CPR</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Hot water heater adjusted to 120° F</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Firearms in the home are locked and safe</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Toxins and medications are out of reach</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Child sees a dentist</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Always uses car safety restraints</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Fire extinguisher in the home</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Eats nutritionally sound diet</p> <p>Sun exposure: <input type="checkbox"/> Frequently <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely <input type="checkbox"/> Remote</p> <p>Amount of milk child drinks daily _____</p> |
|--|--|

<b>PERSONAL MEDICAL HISTORY:</b> Circle if your child's had		
ADD/ADHD/Behavior/Social issues Anemia Asthma Bladder Infections Broken Bones Bronchitis Depression Developmental Issues Diabetes Drug Or Alcohol Problems	Ear Infections - <i>frequent</i> Eating Disorder Headaches Head Injuries Hearing Problems Hives Jaundice Joint Dislocations Kidney Disease	Meningitis Physical abuse Pneumonia Polio Rheumatic Fever Seizure Or Epilepsy Stomach Ulcer or Reflux Thyroid Problems Vision Problems

**SURGERIES:** Check if child's had:  Tonsillectomy  Adnoidectomy  Appendectomy  Ear Tubes

List any other surgeries:

Type _____ Year _____	Type _____ Year _____
Type _____ Year _____	Type _____ Year _____
Type _____ Year _____	Type _____ Year _____

**HOSPITALIZATIONS** (Other than for surgery) Please list:

Date \_\_\_\_\_ Reason \_\_\_\_\_  
 Date \_\_\_\_\_ Reason \_\_\_\_\_  
 Date \_\_\_\_\_ Reason \_\_\_\_\_  
 Date \_\_\_\_\_ Reason \_\_\_\_\_  
 Date \_\_\_\_\_ Reason \_\_\_\_\_

Is there anything else about your child's medical history that you would like the doctor to know? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**TESTS / EXAMS:** Check and indicate year

Physical or Sports exam: Year \_\_\_\_\_  Eye Exam: Year \_\_\_\_\_  
 Other (list) \_\_\_\_\_ Year \_\_\_\_\_

**FOR FEMALES ONLY**

Date of last period: \_\_\_\_\_

**MOM'S PREGNANCY AND CHILD'S BIRTH HISTORY:**

Mother's pregnancy was  Uncomplicated  Complicated – how? \_\_\_\_\_

How long was baby in hospital \_\_\_\_\_ Birth Weight \_\_\_\_\_

While pregnant did mother:

Yes  No Use alcohol or drugs  Yes  No Use tobacco  
 Yes  No Get sick \_\_\_\_\_  Yes  No Take medication: \_\_\_\_\_  
 Yes  No Need any special tests \_\_\_\_\_  Yes  No Have problems with labor  
 Yes  No Have problems with delivery  Yes  No Have health or adjustment problems after birth for either baby or mother: \_\_\_\_\_

**FAMILY HISTORY:**

RELATIONSHIP	NAME	BIRTH YEAR (if living)	AGE AT DEATH	CAUSE OF DEATH
Father				
Mother				
Brothers & Sisters				

If there is a family history of any of the following, circle the relationship of any that applies:

	Relationship		
Alcohol or other substance abuse	Mother	Father	Sibling
Asthma	Mother	Father	Sibling
Breast Cancer	Mother	Father	Sibling
Heart Disease	Mother	Father	Sibling
Colon Cancer	Mother	Father	Sibling
Deafness	Mother	Father	Sibling
Depression/Suicide/Mental illness	Mother	Father	Sibling
Diabetes	Mother	Father	Sibling
Epilepsy/Seizures	Mother	Father	Sibling
Hepatitis (type _____)	Mother	Father	Sibling
Tuberculosis	Mother	Father	Sibling

Other significant family history: \_\_\_\_\_

**SOCIAL HISTORY:**

Yes  No Child is adopted

Mother's Occupation \_\_\_\_\_ Father's Occupation \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Names and dates of birth of persons *living in child's household*, and their relationship to child: \_\_\_\_\_

Life changes (new siblings, divorce, or death) in the family in the past 12 months: \_\_\_\_\_

Do you have any religious practices that would affect how we medically care for your child?  YES  NO

Please list other healthcare providers your child is receiving care from (indicate name & reason): \_\_\_\_\_

**REVIEW OF SYSTEMS:** Circle any/all of the following symptoms that you are **CURRENTLY** concerned about:

GENERAL HEALTH

- No complaints
- Fever
- Chills
- Sweats
- Loss of appetite
- Fatigue
- Weakness
- Don't feel well
- Weight change
- Wake up tired
- Day fatigue/sleepy
- Snoring
- Sleep problems

EYE

- No complaints
- Blurring
- Double vision
- Irritation/Itching
- Redness
- Discharge
- Vision loss
- Eye pain
- Light hurts eyes

EAR/NOSE/THROAT

- No complaints
- Earache
- Ear discharge
- Ear ringing/buzzing
- Decreased hearing
- Nasal congestion
- Nasal discharge
- Postnasal drip
- Nosebleeds
- Sore throat
- Hoarseness
- Itching nose/eyes
- Sneezing

CARDIOVASCULAR

- No complaints
- Chest discomfort
- Pounding/racing heart
- Lightheadedness
- Passing out/fainting
- Shortness of breath with activity
- Shortness of breath lying down
- Sudden waking with shortness of breath
- Swelling in feet/ankles
- Leg pain with exercise

RESPIRATORY

- No complaints
- Coughing
- Wheezing
- Shortness of breath at rest
- Coughing up phlegm
- Coughing up blood
- Painful breathing

GASTROINTESTINAL

- No complaints
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Change in bowel habits
- Abdominal pain
- Dark black stools
- Red blood in stools
- Gas/bloating
- Indigestion/heartburn
- Swallowing problems
- Painful swallowing
- Jaundice

GENITAL/URINARY

- No complaints
- Painful urination
- Blood in the urine
- Frequency
- Genital sores
- Males:
  - Penis discharge
  - Urinating more often
- Females:
  - Urgency
  - Hesitancy
  - Vaginal Discharge
  - Missed periods
  - Abnormally Heavy periods
  - Abnormal Vaginal bleeding
  - Pelvic Pain

MUSCULOSKELETAL

- No complaints
- Neck pain
- Upper back pain
- Lower back pain
- Joint pain
- Joint swelling
- Joint stiffness
- Muscle cramps
- Muscle weakness
- Pain radiating down leg

DERMATOLOGY

- No complaints
- Rash
- Itching
- Dryness
- Changing lesions
- Non-healing sores

NEUROLOGY

- No complaints
- Weakness of a limb
- Numbness/tingling in arms/legs
- Seizures
- Tremors
- Dizziness
- Loss of vision
- Balance problems
- Frequent headaches
- Severe headaches
- Difficulty speaking
- Difficulty swallowing
- Clumsiness
- Confusion
- Memory loss

PSYCHIATRIC

- No complaints
- Feel down, depressed
- Feel overwhelmed
- Little interest/pleasure in doing things
- Anxious or worried
- Excessive sleep
- Inadequate sleep
- Change in appetite
- Difficult to concentrate
- Thoughts of suicide
- Hallucinations
- Fears

ENDOCRINE

- No complaints
- Get cold easily
- Overheat easily
- Drinking more fluids than usual
- Eating more than usual
- Urinating more than usual
- Unintended weight change

HEMATOLOGY

- No complaints
- Abnormal bruising
- Bleeding problems
- Bleeding gums
- Frequent nosebleeds
- Enlarged lymph nodes

ALLERGY IMMUNOLOGY

- No complaints
- Hives
- Allergic Rash
- Allergy Symptoms
- Seasonal Allergies
- Food Intolerances
- Animal Intolerances
- Recurring/Frequent Infections

BREAST

- No complaints
- Breast lump L or R
- Breast pain
- Breast tenderness
- Breast redness
- Nipple discharge
- Bloody nipple discharge
- Breast enlargement

ANY OTHER HEALTH CONCERNS:

---



---



---



---



---



---



---



---