PEDIATRIC (0-17) - FAMILY, MEDICAL, & SOCIAL HISTORY (two pages)

NAME _____ DOB _____

ALLERGIES ☐ None (please list allergies **and what happens to you when you take it**)
Drug Allergies: _____
_____
Food Allergies:_____

CURRENT MEDICATIONS ☐ None
_____ _____
_____ _____

OTHER MEDICAL PROVIDERS: (Please list all of your healthcare providers)
Specialists: _____
Others: _____

CHILD'S MEDICAL HISTORY: (please check all that apply)

☐ Allergies - seasonal	☐ Headaches, migraine/tension	☐ UTI, recurring
☐ Allergies – perennial	☐ Hemophilia, A or B	☐ Weight issues (gain or loss)
☐ Anemia	☐ History of Fracture _____	☐ Other: _____
☐ Asthma	☐ Irregular Heart Rhythm	_____
☐ Cancer, _____	☐ Kidney Stones	_____
☐ Diabetes, Type I or II	☐ Psychological Illnesses	
☐ GERD/ Reflux	☐ Thyroid Disease	

CHILD'S SURGICAL HISTORY: (Please indicate date & details if possible)

☐ Appendectomy	☐ Hernia Repair	☐ Tubes in Ears
☐ Arthroscopy: _____	☐ Mole Removal _____	☐ Other: _____
☐ Biopsy: _____	☐ Orthopedic Surgery: _____	_____
☐ Fracture Repair, _____	☐ Tonsil/Adenoidectomy	_____

SUBSTANCE ABUSE HISTORY: ☐ None Other: _____

MENTAL HEALTH HISTORY: ☐ None Other: _____

COMMUNICABLE DISEASE HISTORY: ☐ None Other: _____

TOBACCO/ALCOHOL/SUPPLEMENTS:
(Tobacco and Alcohol for adolescent and older, **Caffeine, Vitamin, and Tobacco Exposure for all ages**)
☐Tobacco use presently ☐ Previous use ☐ Never smoked
If present or previous use: ☐ Cigarettes ☐ Cigars ☐ Smokeless tobacco
How many/day? _____ How long have you/did you used tobacco? _____ Quit when? _____

Do you use **Alcohol**? ☐ None ☐ Beer ☐ Wine ☐ Liquor How much? _____ How often? _____

Caffeine intake: ☐ Coffee ☐ Tea ☐ Soda ☐ Chocolate How much? _____ How often? _____

Vitamin or Diet Supplements: Type: _____ How often? _____

Child's Tobacco/Smoke Exposure: Who smokes in the house with child? _____
_____

SOCIAL HISTORY:
Parent's marital status:
☐ Single, live together ☐ Single, live apart ☐ Married ☐ Divorced ☐ Widowed ☐ Remarried

Number of Siblings: _____ Other Living Arrangements: ☐ Adopted ☐ Foster Care
Who lives in your household with child? _____

Parents - JOB/EMPLOYMENT:
Father employed? ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Homemaker ☐ Student ☐ Disabled

Mother employed? ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Homemaker ☐ Student ☐ Disabled

Where do/did you work: Father_____ Mother_____

What is/was your job: Father_____ Mother_____

SCHOOL/DAYCARE: ☐ Daycare ☐ Pre-K ☐ Kindergarten ☐ Grade in school: _____

CHILD'S WORK HISTORY: _____

Religion: (any needs or concerns affecting your healthcare) _____

FAMILY HISTORY: Indicate which family member with an **x** in the column
Mat GM/GF = maternal grandmother/grandfather Pat GM/GF = paternal grandmother/grandfather

	Mother	Father	Brother	Sister	Son	Daughter	Mat GM	Mat GF	Pat GM	Pat GF	Mat Uncle	Mat Aunt	Pat Uncle	Pat Aunt
Alcoholism/Drug Abuse														
Alzheimer's Disease:														
Asthma/Bronchitis/Emphysema														
Bleeding Tendency:														
Cancer, _____														
Diabetes, Type I or II:														
Enlarged Prostate:														
Gall Stones:														
Heart Disease:														
Heart problem **under age 40**														
High Blood Pressure:														
High Cholesterol:														
Kidney Disease:_____														
Marfan Syndrome														
Obesity:														
Osteoarthritis:														
Osteoporosis:														
Psychiatric Illness														
Rheumatoid Arthritis:														
Seizure Disorder:														
Stroke:														
Sudden death **under age 40**														
Thyroid Disease:														
Other:_____														

ADDITIONAL COMMENTS, QUESTIONS, OR CONCERNS: _____

_____

Date: _____ Signature: _____