

## Pediatric Patient History Form

Family Medicine Center - Clinic Regional Physicians

<b>Patient Name</b>	<b>Date of Birth</b>	<b>Today's Date</b>
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We are currently using an electronic medical record system for the documentation of all patient visits. If you are a new patient to our office, or if you are a patient we have not seen in awhile, we are asking that you please complete the following form so we may enter your medical history into the system. Please be as detailed as possible when answering the questions. All information will be kept strictly confidential in compliance with federal HIPPA regulations.

### Allergies

Please list all allergies to medications, food, latex, tape, dye, etc. that your child may have.
Please also note the type of reaction experienced with the drug, food, etc.

**No known allergies**

Allergen	Reaction experienced

### Birth Information:

Patient's Birth Weight:	Patient's Birth Length:
Gestational Age (weeks)	
Delivery Method:	<input type="checkbox"/> Vaginal Birth <span style="margin-left: 100px;"><input type="checkbox"/> Cesarean Section</span>
Feeding:	<input type="checkbox"/> Bottle <span style="margin-left: 100px;"><input type="checkbox"/> Breast Fed</span>
Additional birth Information you would like to share:	

### Past Medical History of child

Please list any medical conditions your child has had. Be as specific as possible.

Medical Condition	When Diagnosed?
<i>Example: Broken arm</i>	<i>2003</i>

### Past Surgical History

Please include all surgeries and procedures child has had, include even minor ones

Type of Surgery/Procedure	Date	Comments
<i>Example: Tonsilectomy &amp; Adenoidectomy</i>	<i>5/01</i>	<i>Age 6</i>

<b>Family History -</b>		<b>Is Patient adopted?</b>		<b>Yes</b>	<b>NO</b>
Father	Alive	Deceased	Age	Cause of Death	
Mother	Alive	Deceased	Age	Cause of Death	
Please list medical problems of family members. Note especially, arthritis, asthma, cancer (specify type and age of diagnosis) diabetes, emphysema, heart, blood pressure, gastrointestinal, seizures, osteoporosis, stroke, depression, and thyroid problems.					
<b>Relative</b>	<b>Medical Condition</b>			<b>Comments</b>	
Mother					
Father					
Grandparents					
Other (specify)					
<b>Personal Tobacco use (for children 12 and older)</b>					
Never	Exposed to second hand smoke?			No	Yes
Quit	Quit Date:	How many packs per day?		How many years?	
Current user of (circle)	Cigarettes	Pipe	Cigars	Snuff	Chew
How many, how often?			What age did you start?		
<b>Alcohol (for children 12 and older)</b>					
None	Yes	Type and how many a week.			
<b>Other Concerns:</b>					
Has child had any blood transfusions?					
How much caffeine does your child consume in a day? (specify type and amount):					
Does your child have any sleep concerns?					
Does your child have any stress concerns?					
Weight Issues?					
Does your child follow a special diet?					
Describe your child's activity/exercise regimen.					
How many hours of T.V. or video games does your child participate in daily?					
Other concerns:					
<b>Medications:</b> Please list all medications your child is currently taking.					
Remember to include all vitamins, supplements and herbal preparations					
<b>Name of Medication</b>	<b>Dose</b>	<b>How often is it taken?</b>		<b>Who prescribed?</b>	
Example: Flinestones Vitamins		1 tablet per day			
Form completed by:			Relationship to patient		
<b>Please provide us with a copy of your child's immunization records.</b>					



