KidMed
Feel better.

PEDIATRIC MEDICAL HISTORY FORM

Patient History Form

Name:	Date of Birth:	E-mail Address:
PCP:	Date of Visit	

Race Ethnicity:	[] White, Non-Hispanic [] Black, Non-Hispanic [] Hispanic [] Asian [] Native American
	[] Native Hawaiian and Other Pacific Islander [] Other:

PAST MEDICAL HISTORY

Birth Hospital:	Pregnancy Problems?	[] N	[] Y	Problem in the nursery	[] N	[] Y
Birth Weight:	Labor/delivery Prob?	[] N	[] Y	Baby home with Mom	[] N	[] Y
Discharge Weight:	---- with Mother	[] N	[] Y	Breast Fed?	[] N	[] Y
Discharge Date:	---- with Baby	[] N	[] Y	How Long?		
Hepatitis B Vaccine given in Hospital?		[] N	[] Y			
Pregnancy Duration:						
Problems in first few months?						
Chronic illnesses/injuries?						
Hospitalizations/Surgeries?						
Behavior Issues?						
School Issues?						
Interests/ Activities:						
Location of previous pediatric care:						

Allergic to any medications?	[] No	[] Yes	List
Adverse reaction to medication?	[] No	[] Yes	List
Allergic to any foods?	[] No	[] Yes	List
Other allergies?	[] No	[] Yes	List

MEDICATIONS

List all medications the patient is currently taking including prescription medications, over-the-counter medications and herbal

SOCIAL HISTORY

Mother's First Name:	Age:	Occupation:
Father's First Name:	Age:	Occupation"
Parents Married? [] Yes [] No		Parents living together? [] Yes [] No
Child's Daytime caregiver?		
Others living in your home?		
Siblings names, gender and ages:		

FAMILY HISTORY					
(mother, father siblings, grandparents, aunts, uncles and cousins)					
Problem	Relationship	Maternal/ Paternal	Problem	Relationship	Maternal/ Paternal
▯ ADD		▯ M ▯ P	▯ Eczema		▯ M ▯ P
▯ Alcohol Abuse		▯ M ▯ P	▯ Heart Disease		▯ M ▯ P
▯ Allergy		▯ M ▯ P	▯ High BP		▯ M ▯ P
▯ Asthma		▯ M ▯ P	▯ Kidney		▯ M ▯ P
▯ Birth Defects		▯ M ▯ P	▯ Mental Illness		▯ M ▯ P
▯ Cancer		▯ M ▯ P	▯ Obesity		▯ M ▯ P
▯ Skin Cancer		▯ M ▯ P	▯ School Problems		▯ M ▯ P
▯ Cholesterol High		▯ M ▯ P	▯ Seizures		▯ M ▯ P
▯ Development		▯ M ▯ P	▯ Stomach/Bowel		▯ M ▯ P
▯ Diabetes		▯ M ▯ P	▯ Thyroid		▯ M ▯ P
▯ Drug Abuse		▯ M ▯ P			
Any other medical condition that "runs in the family"?					

DEVELOPMENT/ BEHAVIOR			
Problems with eating?	▯ N ▯ Y	Problems in School?	▯ N ▯ Y
Problems with sleeping?	▯ N ▯ Y	Problems with peers/siblings?	▯ N ▯ Y
Problems with elimination?	▯ N ▯ Y	Problems with toilet training?	▯ N ▯ Y
Problems with temper?	▯ N ▯ Y	Problems with behavior?	▯ N ▯ Y
At what age did your child sit alone?		At what age did your child speak words?	
At what age did your child walk?			
Do you have any concerns about your child's development?			

SAFETY/ ENVIRONMENT			
Does your child always wear a seat belt?	▯ N ▯ Y	Are there any smokers in the house?	▯ N ▯ Y
Does you child always wear a helmet?	▯ N ▯ Y	Does your home contain lead paint?	▯ N ▯ Y
Do you have working smoke detectors	▯ N ▯ Y	Do you have firearms in the house?	▯ N ▯ Y
Do you have a carbon monoxide detector?	▯ N ▯ Y	If yes, is ammunitions stored separately?	▯ N ▯ Y

TUBERCULOSIS SCREEN	
Has your child lived with or spent time with anyone who was positive for tuberculosis?	▯ N ▯ Y
Has your child lived or spent time with anyone who has a positive skin test for tuberculosis?	▯ N ▯ Y
Has anyone in your household come to the United States from another country?	▯ N ▯ Y
Has you child lived with or spent time with adults who were homeless, lived in a shelter?	▯ N ▯ Y
Has your child lived with or spent time with adults who have AIDS or are infected with HIV	▯ N ▯ Y
Has your child lived with or spent time with adults who used intravenous drugs or street drugs?	▯ N ▯ Y
Has your child lived with or spent time with adults who lived in a correctional facility, nursing home, or mental	▯ N ▯ Y
If you child has had a positive skin test for tuberculosis in the past, inform your child's health care	

OTHER ISSUES YOU WOULD LIKE TO DISCUSS WITH PHYSICIAN

PLEASE PROVIDE A COPY OF YOUR CHILD'S IMMUNIZATION RECORD

Thank you for helping us take better care of your child.

Parent/Guardian (name) _____

Parent/Guardian Signature _____ Date _____