NOE VALLEY PEDIATRICS

PEDIATRIC MEDICAL HISTORY

PATIENT NAME: _____ Today's Date: _____

PRESENT HEALTH CONCERNS: _____

BIRTH HISTORY

Date of Birth: _____ Premature: □ Y □ N

Birth Weight: _____ Birth Length: _____

Birthplace (Hospital, City): _____

Were there any problems during pregnancy? _____

Were there any problems during labor? _____

MEDICAL HISTORY

Has your child ever had any:

Serious or chronic illnesses?	□ Y	□ N	Describe: _____
Surgeries?	□ Y	□ N	Describe: _____
Overnight hospitalizations?	□ Y	□ N	Describe: _____
Serious injuries or accidents?	□ Y	□ N	Describe: _____
Allergic reactions to medications / immunizations?	□ Y	□ N	Describe: _____
Asthma, recurrent cough, bronchitis, or pneumonia	□ Y	□ N	Describe: _____
Nasal allergies	□ Y	□ N	Describe: _____
Frequent ear infections or sore throat	□ Y	□ N	Describe: _____
Problems with ears or hearing	□ Y	□ N	Describe: _____
Problems with eyes, vision or teeth	□ Y	□ N	Describe: _____
Eczema or other skin issues	□ Y	□ N	Describe: _____
Frequent headaches or other neurologic problems	□ Y	□ N	Describe: _____
Frequent abdominal pain	□ Y	□ N	Describe: _____
Constipation requiring doctor visits	□ Y	□ N	Describe: _____
Bladder/kidney problems or bedwetting	□ Y	□ N	Describe: _____
Any heart problems/murmur	□ Y	□ N	Describe: _____
Anemia or bleeding problem	□ Y	□ N	Describe: _____
Thyroid or other gland problem	□ Y	□ N	Describe: _____
Diabetes	□ Y	□ N	Describe: _____
ADD/ADHD	□ Y	□ N	Describe: _____
Mental or behavioral issues	□ Y	□ N	Describe: _____
Other issues not listed above	□ Y	□ N	Describe: _____

IMMUNIZATIONS

Please list any immunizations that the patient has received at other health care facilities along with your best estimate of the month and year of each immunization.

Hepatitis A: _____ Measles: _____ Mumps: _____ Rubella: _____ MMR: _____

Hepatitis B: _____ Pneumovax: _____ Tdap: _____ Varicella: _____ Other: _____

MEDICATIONS AND ALLERGIES

Please list all current medications, vitamins and supplements (even if only used intermittently):

_____

_____

Please list all allergies or reactions to medicines, vaccines or foods:

_____

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PATIENT NAME: _____

HOUSEHOLD INFORMATION

Please list patient's family and household members:

Name	Age	Relationship	Occupation/Employer

Are the patient's parents: □ Married □ Unmarried/Partners □ Separated □ Divorced

Childcare Situation: □ Parents □ Others: _____

Do any family members smoke? □ Yes □ No Is violence at home a concern? □ Yes □ No

Are there pets in the home? □ Yes □ No Are there guns in the home? □ Yes □ No

FAMILY HISTORY

Have any family members (parents, siblings, grandparents, aunts, uncles) had the following? If so, please list who and provide details.

- ☐ Alcohol / Drug Abuse _____
- ☐ Allergies _____
- ☐ Asthma _____
- ☐ Blood Disorders _____
- ☐ Bone Disorders _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Endocrine Disease _____
- ☐ Ear / Nose / Throat Disorders _____
- ☐ Eye Disorders _____
- ☐ Gastrointestinal Disorders _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Immune Disorders _____
- ☐ Joint Problems _____
- ☐ Kidney Disease _____
- ☐ Liver Disease _____
- ☐ Lung Disease _____
- ☐ Migraine Headaches _____
- ☐ Metabolic Disorders _____
- ☐ Obesity _____
- ☐ Seizure Disorders _____
- ☐ Skin Disorders _____
- ☐ Stroke _____
- ☐ Thyroid Disorders _____
- ☐ Mental Health Issues _____
- ☐ Other Medical History _____