



Pediatric Medical History Form

Name (print): Sex: M / F Today's Date:
Phone: Date of Birth: Age: Height/Weight
Name of his/her Pediatrician / Primary Care Doctor Phone:
Was he/she referred by a physician? Y / N Name: Phone:

1. Reason for today's visit: (indicate BODY PART, briefly state history of the problem and when the symptoms began): Left or Right (circle)

2. Has he/she ever had a similar problem or injury to the area/region being assessed today? (explain) Is this a re-injury? (circle) Y / N

3. Problem is due to: (check) Car Accident Work Related School Injury Other

4. Is he/she presently under treatment for any medical condition?

5. Has he/she ever had previous bone, joint or nerve problems previously? (circle) Y / N (explain)

6. Does he/she have any medical devices implanted in his/her body? (pacemaker, portacath, pump, rods, prosthesis, etc.)

7. Medications: (list name(s) and dosage(s) including any blood thinners, and over-the-counter medications)

Table with 6 columns: Medicine, Dose, # per day, Medication, Dose, # per day

8. Allergies (medicines, LATEX):

9. Does he/she have any unusual allergies/reactions to medications? (describe)

\*\*If he/she is a prior patient and have been treated within the past year you must sign the disclaimer below indicating that there have not been any changes to his/her medical history.

\*\*\*If there have been changes to his/her medical history, bypass this disclaimer and indicate all changes.

DISCLAIMER: I confirm that there have NOT been any changes in his/her medical history since the last date of registration.

Parent/Guardian Signature: Date:

Prior History: (list all surgeries, major illnesses, injuries and hospitalizations with dates)

Table with 3 columns: Date, Surgery / Major Illness / Injury, Hospitalized

Social History: Occupation - Is he/she working now? Yes / No

Is she or could she be pregnant? (circle) Y / N

Does he/she now or has he/she had a drug or alcohol problem?

Does he/she exercise / play sports / hobbies (describe briefly)?

Is he/she presently going to school? Y / N Education Level: K 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4

PLEASE COMPLETE REVERSE SIDE

Name (print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Review of Symptoms:** Are you currently having problems with any of the following? (circle all that apply)

**EYES:**

Glasses  
 Cataracts  
 Glaucoma  
 Other \_\_\_\_\_

**SKIN:**

Dermatitis  
 Rashes  
 Psoriasis  
 Eczema  
 Other \_\_\_\_\_

**EAR/NOSE/THROAT:**

Deafness  
 Allergies  
 Sinus Trouble  
 Nosebleeds  
 Chronic Sinus Infection  
 Trouble Swallowing  
 Other \_\_\_\_\_

**NEUROLOGIC:**

Stroke  
 Seizures  
 Dizziness  
 Multiple Sclerosis  
 Numbness/Tingling  
 Parkinson's  
 Fainting  
 Backouts/Falls  
 Other \_\_\_\_\_

**INFECTIOUS DISEASE:**

HIV  
 Hepatitis  
 Lyme Disease  
 Positive TB test  
 Other \_\_\_\_\_

**HEART AND**

**CARDIOVASCULAR:**

Chest Pain  
 Heart Attack  
 Palpitations  
 Heart Disease  
 Circulation problems  
 Blood Pressure HI/LOW  
 Blood Clots  
 Arrhythmia

**Cont. HEART AND**

**CARDIOVASCULAR:**

Varicose Veins  
 Rheumatic Fever  
 Heart Murmur  
 Pulmonary Embolus  
 Other \_\_\_\_\_

**ENDOCRINE:**

Diabetes  
 Thyroid Disease  
 Other \_\_\_\_\_

**GENITOURINARY:**

Bladder Infection  
 Kidney Disease  
 Incontinence  
 Kidney Infection  
 Kidney Stones  
 Frequent Urination  
 Painful Urination  
 Bloody Urine  
 Frequent Nighttime Urination  
 Prostate Problem  
 Other \_\_\_\_\_

**PULMONARY/RESPIRATORY:**

Asthma  
 Emphysema  
 Bronchitis  
 Pneumonia  
 Wheezing  
 Shortness of Breath  
 Sleep Apnea  
 Other \_\_\_\_\_

**HEMOTOLOGIC/LYMPHATIC:**

Lymphedema  
 Anemia  
 Sickle Cell  
 Easy Bleeding  
 Transfusion  
 Abnormal Bruising  
 Blood Disorder  
 Other \_\_\_\_\_

**PSYCHOLOGIC:**

Depression  
 Anxiety  
 Bipolar Disorder  
 Other \_\_\_\_\_

**GASTROINTESTINAL:**

Ulcers  
 Reflux  
 Crohn's  
 Nausea  
 Vomiting  
 Diarrhea  
 Constipation  
 Bloody/Black Bowel Movement  
 Abdominal Pain  
 Liver Disease  
 Jaundice  
 Other \_\_\_\_\_

**CONSTITUTIONAL:**

Fever  
 Weight Loss  
 Loss of Appetite  
 Night Sweats  
 Fatigue  
 Chills  
 Other \_\_\_\_\_

**ONCOLOGIC:**

Cancer  
 Type \_\_\_\_\_

**MUSCULOSKELETAL:**

Rheumatoid Arthritis  
 Osteoporosis  
 Joint Pain  
 Back Pain  
 Neck Pain  
 Slipped Disc  
 Leg Pain  
 Joint Stiffness/Swelling  
 Gout  
 Other \_\_\_\_\_

**OB/GYN**

Pregnant Now? **Y / N**  
 Other \_\_\_\_\_

**Comments:** \_\_\_\_\_

**Family Medical History:** List medical problems of your relatives (ex. diabetes, cancer):

Grandparents: \_\_\_\_\_

Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Siblings: \_\_\_\_\_

Children: \_\_\_\_\_