



Pediatric History Information

Name: _____ Today's Date: _____ Date of Birth: _____

Primary care physician: _____ Referred by: _____ Pharmacy Phone: _____

Allergies:

- Medications: _____
 Food: _____
 Contactants: _____
 Environmental: _____

Family History: Please check all of the conditions someone in your immediate family (mother, father, brother, sister) has been diagnosed with (not including yourself).

- | | | |
|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Liver Disease | |

Past Medical History: Please check all that apply to you.

- | | | |
|---|---|--|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Environmental Allergies | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headache | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Attention Deficit Hyperactivity Disorder | <input type="checkbox"/> Infectious Mononucleosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Joint problems | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Murmurs | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Rash | |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Rheumatic Fever | |

Surgeries: Please check all that apply to you:

- | | |
|--|--|
| <input type="checkbox"/> Adenoidectomy, date _____ | <input type="checkbox"/> Appendectomy, date _____ |
| <input type="checkbox"/> Inguinal Hernia Repair, date _____ | <input type="checkbox"/> Tonsillectomy, date _____ |
| <input type="checkbox"/> Umbilical Hernia Repair, date _____ | <input type="checkbox"/> Other: _____ |

Social History: Please check all that apply for you.

- Smoking:
 Never Quit, when _____ Yes, how much _____
- Do you exercise regularly?
 Yes What? _____ How often? _____ No

Current Medications (with dosage):

Review of Systems:

Have you recently experienced any of the following: (please check all that apply)

General:

- Chills
- Fever
- Night Sweats
- Weight gain > 10 lbs
- Weight loss < 10 lbs

Skin:

- Bruising
- Pallor
- Rash
- Color Change

HEENT:

- Headache
- Head Injury
- Seasonal Allergies

Respiratory:

- Cough
- Low Exercise Tolerance
- Wheezing
- Difficulty Breathing

Cardiovascular:

- Chest Pain
- Fainting
- Blacking Out
- Hypertension
- Irregular Heart Beat
- Palpitations
- Shortness of Breath
- Swelling of Extremities

Gastrointestinal:

- Abdominal Pain
- Change in Bowel Habits
- Heartburn
- Nausea
- Vomiting

Male Genitourinary

- Blood in Urine
- Change in Bladder Habits
- Testicular Pain
- Testicular Mass
- Change in Urinary Stream

Musculoskeletal:

- Back Pain
- Joint Pain
- Joint Redness
- Joint Stiffness
- Joint Swelling
- Muscle Pain
- Muscle Weakness

Neurological:

- Decreased Memory
- Dizziness
- Fainting
- Loss of Consciousness
- Seizures

Psychiatric:

- Anxiety
- Depression
- Mood Changes

Endocrine:

- Cold Intolerance
- Excessive Thirst
- Thyroid Problems

Hematology:

- Anemia
- Easy Bruising
- Prolonged Bleeding