Pediatric Associates of Franklin

Pediatric Medical History Form

Your answers on this form will help your provider understand your child's medical history.

CHILD'S NAME: _____ DATE OF BIRTH:_____

LEGAL GUARDIAN:_____

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DATE OF FORM COMPLETION: _____

MEDICATIONS:

Medication _____ Prescribing provider _____ How many times a day

Dose _____

_____

_____

MEDICATION ALLERGIES: □ No □ Yes _____

if yes, to what medication(s) _____

what was the reaction _____

IMMUNIZATION HISTORY (please supply a copy of your child's immunization record):

To the best of my knowledge, my child is up to date on his/her immunizations □ No □ Yes

If no, why? _____

BIRTH HISTORY:

Please indicate any medical problems during pregnancy _____

Please list any medications taken during the pregnancy_____

Any drug or alcohol use during the pregnancy □No □ Yes _____

Delivered by □ elective C-section □ emergent C-section □ forceps □ vacuum extraction □ normal vaginal delivery

Number of weeks gestation_____

Birth weight_____ Discharge weight_____

Did the baby receive the Hepatitis B vaccine □ No □ Yes If yes, date given __ _____

Please indicate any medical problems during the newborn period_____

Name of hospital where infant was born_____

HOSPITALIZATIONS:

Has your child every stayed overnight in a hospital? □ No □ Yes

If yes, when and why? _____

_____

SURGICAL/OUTPATIENT PROCEDURE HISTORY: (ex: ear tubes, tonsillectomy, etc)

Please indicate any surgeries or procedures your child has had. Please include the year the surgery/procedure was performed.

_____

_____

_____

Complete both sides

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SOCIAL HISTORY:
Is the child cared for by anyone other than the biological parents? □No □ Yes
If yes, by whom and how frequently? _____
Does anyone in your home smoke? □ No □ Yes
Siblings (please note if step or half):
_____
_____

PERSONAL MEDICAL HISTORY:
Please check if your child has had any of the following medical problems:

□ ADD/ADHD	□ Chicken pox	□ Headaches	□ Liver disease/Hepatitis
□ Allergies	□ Concussion	□ Hearing problems	□ Recurrent ear infections
□ Anemia	□ Diabetes	□ Heart murmur	□ Reflux/GERD
□ Asthma	□ Eczema	□ Congenital heart disease	□ Seizures
□ Bleeding disorder	□ Fracture	□ High blood pressure	□ Urinary Tract Infections
□ Bronchiolitis	□ Handicaps/Disabilities	□ Kidney disease	□ Vision problems

OTHER PROVIDERS: (Please list any other specialists your child sees. Ex: physical therapy, ENT, etc)

_____
_____
_____

GYN HISTORY (if applicable):
Age of first period _____ years Has not had menses yet_____

FAMILY HISTORY:
Please indicate if your child has a family history (**parents, siblings, maternal/paternal grandparents, aunts, or uncles**) of any of the following: ****Please specify maternal/paternal relation**

Diagnosis	**Family Member**	**Diagnosis**	**Family Member**
□ ADD/ADHD	_____	□ Hearing disability	_____
□ Alcohol/Drug Abuse	_____	□ High cholesterol	_____
□ Allergies	_____	□ High blood pressure	_____
□ Asthma	_____	□ HIV/AIDS	_____
□ Birth defects	_____	□ Learning disability	_____
□ Blood disorders	_____	□ Mental illness	_____
□ Cancer, type	_____	□ Migraines	_____
□ Heart disease	_____		_____
(heart attack, bypass, stents)		□ Scoliosis	
□ Deafness/Hearing problems	_____	□ Seizure disorder	_____
□ Depression	_____	□ Speech problems	_____
□ Developmental delay	_____	□ TB/Lung disease	_____
□ Diabetes	_____	□ Stroke	_____
□ Genetic disorder	_____	□ Thyroid disease	_____
□ Hepatitis/Liver disease	_____	□ Other	_____
			_____