Child 0-13 Pediatric Medical History Update

Mother's Name_____ Age_____ Patient's Name _____
Father's Name_____ Age_____ Date of Birth_____
Occupation: Mother_____ Father_____ Today's Date _____

If adults in the household work outside the home, what child care arrangements are made for this child?
_____
_____

A. Past Medical History

1. Date of last checkup:_____
2. Has your child had allergic reactions to any medications, food, or insects? No Yes
3. Any recent hospitalizations or operations? No Yes
4. Any serious injuries? No Yes
5. Any ongoing medical problems? No Yes
6. Are any medications taken regularly? _____

Explain any Yes answers:
_____
_____
_____

B. Family History

1. Circle any of the diseases below that this child's blood-related relatives have had. Include: mother (M), father (F), grand-parents(GP), brothers/sisters(B or S), aunts/uncles(A or U)

Disease	Member(s) Affected	Disease	Member(s) Affected	Disease	Member(s) Affected
AIDS	_____	Diabetes	_____	High Blood Pressure	_____
Allergies	_____	Drug/Alcohol Problems	_____	Mental Illness	_____
Anemia	_____	Heart Prob.	_____		
Asthma	_____				
Cancer	_____	Genetic Disease	_____		
Tuberculosis	_____				

Early Death (before age 40; including SIDS)____ High Cholesterol_____

Notes:_____
_____

C. **Feeding and Nutrition**

1. Is your child's appetite usually good? No Yes
2. Any weight change? No Yes

D. Spirituality

1. Does your family attend religious services regularly? No Yes
2. Do you pray with your child? No Yes
3. How important is God to your family? _____

E. **Review of Systems**

1. Has your child had frequent ear infections? No Yes
2. Does your child have any eye problems? No Yes
3. Frequent headaches? No Yes
4. Frequent colds or sore throat? No Yes
5. Any asthma, pneumonia, or recurrent cough? No Yes
6. Ever had a heart murmur or heart problem? No Yes
7. Any recurrent diarrhea or constipation? No Yes
8. Any problems with urination? No Yes
9. Any seizures or nervous system problems? No Yes
10. Any eczema, hives, or other skin problems? No Yes
11. Has your child ever been anemic? No Yes
12. Any orthopedic (bone or muscle) problems (e.g., scoliosis, foot problems, etc.)? No Yes
13. Any other medical problems? _____
_____
_____

F. **Development/Behavior**

1. How does this child compare with others his/her age?
_____
_____
2. What grade is he/she in? ____
3. Any problems sleeping? No Yes
4. Does he/she get along with other children? No Yes
5. Has this child had trouble in school? No Yes
6. Circle if your child has had any of the following:
nail biting, thumb sucking, bed wetting, nightmares, bad temper, hyperactivity, problems with discipline, speech problems, problems with toilet training, speech problems, other problems

G. **Environment/Safety**

1. Do you live in a private house, townhouse, mobile home, apartment, other? (Circle one)
2. Is there a working smoke alarm on each floor of your home? No Yes
3. Does your child always use a car seat/seat belt when riding in a car? No Yes
4. Are there any smokers in your home? No Yes
5. Are there any problems with the condition of your home (peeling paint, insects, rats, or mice)? No Yes
6. Approximate age of your home/apartment? _____
7. Does your child always wear a helmet when riding a bicycle? No Yes