Annandale Family Practice – Pediatric Medical History Form

In order to ensure that we are aware of your child's complete medical history and to better assess his/her individual risk factors, please take a few minutes to answer these questions.

Name: _____ Date: _____
Date of Birth: _____

Other Household Members: (Name, age, and relation)
_____
_____
_____

Birth History: (Circle all that apply)
Infertility Y/N
Pre term: Infertility/Gestational Diabetes/Preeclampsia/Preterm labor/Hyperemesis gravita/High blood pressure
Intrapartum: vaginal delivery/c-section/forceps/vacuum/meconium aspiration/placenta previa/episiotomy
Post partum: maternal fever/neonatal fever/hypoglycemia/jaundice/hypothermia

Previous Surgeries or Hospitalizations:
1._____ 3._____
2._____ 4._____

Vaccination Record:
Up to date_____ Missing_____ Refused Vaccines_____ Adverse Reaction_____

Allergies: (food, medication, environmental)
1._____ 3._____
2._____ 4._____

Medications: (include over the counters, herbals, supplements, and vitamins)

Name of Medication	Dose	Directions

Preferred Pharmacy: _____ **Phone** #:_____

Social History:
Smokers in the home_____ Smoke outside_____ Pets in home_____ Guns in home_____
Lead paint in home_____ Relationship with siblings_____ Caretaker_____ Daycare_____
School_____ Grade_____ Gets along with other children_____ Gets along with teachers_____
Parents relationship: single parent/married/domestic partnership/divorced/separated/estranged

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Family History: (relation, age at diagnosis; if deceased, age at time of death)

Heart Disease: _____ High Blood Pressure: _____
Heart Failure:_____ High Cholesterol: _____
Stroke: _____ Aneurysm: _____
Poor Circulation: _____ Amputation: _____
Asthma: _____ Autism: _____
Cancer (type): _____ Mental Retardation: _____
Diabetes: _____ Sickle Cell Anemia: _____
Thyroid Disease: _____ Cystic Fibrosis: _____
Hepatitis: _____ Congenital Deformity: _____
Dementia: _____ Congenital Disease: _____
Hearing Loss: _____ Vision Loss: _____
Other: _____
_____

Review of Symptoms: (Circle all the symptoms that you have been experiencing)

Cardiac: chest pain, palpitations, pressure in the chest, heaviness in the chest, heart murmur
Lungs: shortness of breath, chronic cough, coughing up blood, wheezing
GI: nausea, vomiting, diarrhea, chronic constipation, hemorrhoids, blood in the bowels, black tarry stools, abdominal pain, pelvic pain, heart burn, indigestion, acid reflux
GU: difficulty urinating, blood in urine, pain with urination, urinary incontinence, frequent urination, waking at night to urinate, circumcision, bedwetting, daytime wetting
Reproductive: vaginal discharge, vaginal itching, heavy/painful/irregular periods, penile discharge, Age of first period _____ Last menstrual period _____
MS: Swelling in legs, chronic joint pain (If yes, which joint _____), back pain (chronic, recurrent), muscle aches, muscle deformity
Derm: lumps, bumps, moles of concern, rash, sores/lesions, tattoo, piercing
Neuro: numbness, tingling, tremor, seizure, convulsions, headaches (migraine, tension, cluster, sinus)
Eyes: vision loss, blurred vision, double vision, blindness
Wears: Glasses _____ Contacts _____ To drive/To read/All the time
Ears: hearing loss, vertigo, ringing in the ears, hearing aid (right/left/both), failed hearing screening
Nose: bloody nose, obstruction, deviated septum, snoring, post nasal drip
Throat: sore throat, lump in throat, change in voice, difficulty swallowing
Psych: depressed, moody, anxiety, panic attacks, hallucinations, tearfulness, lack of motivation
Gen: fever, chills, weight loss, weight gain, fatigue, lack of energy, change in appetite, change in sleep

Other: _____
_____
_____
_____