Name_____ DOB_____/_____/_____

Personal Health History Form- Pediatric

***Past Medical History**: Have you ever been diagnosed with any of the following?*

Cardiovascular
□Heart Defect_____
□Heart Murmur_____
□Other_____
Genitourinary
□Frequent UTI's_____
□ Incontinence/ Bedwetting_____
Dermatologic
□Acne_____
□Abnormal/Precancerous Moles_____
□Eczema
□Other_____
Respiratory
□Chronic Cough_____
□Asthma_____
□Seasonal Allergies_____
□Other:_____
Endocrine
□Diabetes: Type 1/Type 2_____
□Other_____
ENT
□Recurrent Ear infections _____
□Recurrent Step _____

Gastrointestinal
□GERD/Reflux_____
□Hernia_____
□Irritable Bowel _____
□Crohn's/Ulcerative Colitis_____
□Other_____
Psychological
□Anxiety/Panic Disorder_____
□Mood Disorder (Bipolar/ Depression)_____
□ADD/ADHD_____
□Other_____
Neurological/Musculoskeletal
□Concussion_____
□Headaches/Migraines_____
□Passing out/ Syncope_____
□Other_____
Female Patients
□Last Menstrual Period_____
□Have you had an abnormal Pap Smear: Yes or No
□Heavy or Long Periods_____
□Using Birth Control _____

***Current Medications**:*

Medication Name	Dose	How often Taken

Additional space available last page

Allergies: □ No Known Medication Allergies □ No Known Food Allergies □No Known Other Allergies

Allergy	Type of Reaction (i.e. rash, swelling, nausea)

Previous Surgeries (please list date) □ No Previous Surgeries

_____

_____

Previous Hospitalization (please list date) □ No Previous Hospitalizations

_____

_____

Name_____ DOB_____/_____/_____

***Family History**:*

Family Member		Medical History (Diabetes, Heart disease, Stroke, Cancer etc.)
Father	□Living DOB:_____ □Deceased age:____	
Mother	□Living DOB:_____ □Deceased age:____	
Brothers _____ Sisters _____	□Living DOB:_____ □Deceased age:____	
Paternal Grandfather	□Living DOB:_____ □Deceased age:____	
Paternal Grandmother	□Living DOB:_____ □Deceased age:____	
Maternal Grandfather	□Living DOB:_____ □Deceased age:____	
Maternal Grandmother	□Living DOB:_____ □Deceased age:____	

Any other significant Family Medical History? _____
_____

Review of Systems

Are you currently experiencing any of the below – Circle any positive response

		General			**Gastrointestinal**
Yes	No	Fatigue: Duration_____	Yes	No	Diarrhea
Yes	No	Weight Gain/Loss	Yes	No	Constipation
Yes	No	Loss of Appetite	Yes	No	Abdominal Pain/Nausea
Yes	No	Fever	Yes	No	Rectal Bleeding
		Cardiovascular	Yes	No	Heartburn/Indigestion
Yes	No	Chest Pain			**Endocrine**
Yes	No	Shortness of Breath	Yes	No	Increased Thirst
Yes	No	Swelling of legs	Yes	No	Increased Urination
Yes	No	Palpitations/Fluttering	Yes	No	Heat/cold intolerance
		Dermatologic			**EENT**
Yes	No	Skin Rash/Itching	Yes	No	Vision Changes
Yes	No	New or changing Moles	Yes	No	Hearing Changes
Yes	No	Skin ulcer/Burn/Abscess	Yes	No	Seasonal Allergies
Yes	No	Easy Bruising/Bleeding	Yes	No	Cough/congestion
		Musculoskeletal/Neuro	Yes	No	Sore throat
Yes	No	Numbness/Tingling	Yes	No	Nose Bleeds
Yes	No	Injury/Fractures			**Urinary**
Yes	No	Joint Pain/Swelling	Yes	No	Burning/Itching
Yes	No	Back Pain	Yes	No	Blood in Urine
Yes	No	Muscle Weakness	Yes	No	Back Pain
		Psychological			
Yes	No	Anxiety/Panic Attacks			
Yes	No	Depression			
Yes	No	Inattentiveness			

Who was your previous Primary Care Provider/Health Clinic? _____