PEDIATRIC HISTORY

DATE: _____

Patient Name:_____ DOB:_____ Gender F M

REVIEW OF MEDICATIONS

MEDICATION	DOSE/FREQUENCY	DISEASE	SIDE EFFECTS

Last Physical/EPSDT:_____ **Eye Exam**:_____ **Dental Exam**:_____
Any allergies (Food included):_____
Any surgeries/procedures/Trauma/Fracture in the past?_____
Any hospitalizations in the past?_____
Vaccines up to date: YES ____ NO ____

OB/GYN HISTORY: **LMP:** _____ **Regular or Irregular Menarche**:_____
Contraception Use: _____ **Hx STD:**_____ **Last Pap**:_____

SOCIAL HISTORY
Coffee/Tea:_____/day **Energy Drinks**:_____/day **Tattoos**:_____
Alcohol: beer/ wine/ liquor_____/day _____week **Tobacco** in the past Y/ N/day x _____ years
Drug Use: none/ Marijuana/ Cocaine/ Heroin/ Pills/ LSD/ Amphetamines_____/day
Sleeping problems:_____ **Enuresis** Y/N **Gain/Lost Weight** Y / N
E**xercise**:_____/day_____/week **Siblings** Y/ N #_____

NEWBORN
Birth Weight: _____ **Hearing Test:** **Passed** **Failed** **PKU Test** **(+)** **(-)**
Delivery Hospital: _____ **Vaginal** **C-Section** **Jaundice** **(+)** **(-)** **Phototherapy Y / N**
Infections in the past: _____
Feeding Problems: _____ **Circumcision: Y / N**
Growth & Development Disorders: _____ **Generic Disorders:** _____

MEDICAL/FAMILY HISTORY: Have yourself or any members of your immediate family been diagnosed with

Condition	Answer	Self	Father	Mother	Sibling	Other relative	Type/Describe
Asthma/ TB	No Yes						
Cancer	No Yes						
Hypertension/Stroke	No Yes						
Fatigue	No Yes						
Chest Pain/ CHD	No Yes						
Renal Failure/KStone	No Yes						
Hyperlipidemia	No Yes						
Diabetes	No Yes						
Brain Aneurysm	No Yes						
Loss of Vision	No Yes						
Thyroid Disease	No Yes						
Migraines/ Seizure	No Yes						
Weight Changes	No Yes						
STD	No Yes						
Depression	No Yes						
Bipo/Sch/Suicide	No Yes						
Anemia/Leukemia	No Yes						

Other Specific Concerns or Comments:
_____