Providence Medical Group

Providence Pediatric Subspecialty Clinic
3831 Piper Street Suite S-220 Anchorage, AK 99508
907-212-4824 Fax: 907-212-4831

Patient Medical History

PATIENT NAME: _____ **Preferred Name:** _____ **DOB:** _____

Reason for today's visit: _____

_____

ALLERGIES: Does the patient have any allergies to medications, foods, or other substances? ☐ Yes ☐ No
If yes, please list all allergies and reactions (including rash, hives, throat swelling, anaphylaxis)

Allergy	Reaction	Allergy	Reaction

MEDICATIONS: Does your child take any medications? ☐ Yes ☐ No
If yes, please list ALL current medications, including over the counter, vitamins/herbal supplements.

Medication Name	Dose	Times a Day	Medication Name	Dose	Times a Day
Preferred Pharmacy Name:			Location:		

Please list any surgeries/procedures and hospitalizations your child has had. ☐ None

Hospitalization or procedures/surgeries	Age	Hospitalization or procedures/surgeries	Age

Please Circle if your child has had or currently has any of the following:

ADD / ADHD	Diabetes	Hearing Loss
Anemia	Ear Infections	Heart Disease / Defect
Anesthesia Problems	Eczema / Skin Disorders / Rash	Liver Disease / Jaundice
Anxiety	Eye Problems	Pneumonia
Asthma / Breathing Problems	Failure to Thrive / Feeding Difficulty	Seasonal Allergies
Autoimmune Disease	Gastric Reflux / Heartburn	Sleep Apnea
Behavioral Problems	Growth Disorder / Short Stature	Speech or Developmental Problems
Bleeding / Clotting Disorders	Heart Disease / Defect	Seizure
Bone Disease / Fractures	High Blood Pressure	Stomach Problems
Cystic Fibrosis	Joint Pain	Thyroid Disorder
Depression	Kidney Disease /Stones	Urine Tract Infections
Other medical history not listed:		

BIRTH HISTORY

Was you child: ☐ Premature ☐ Full Term ☐ Late ☐ Patient is adopted
☐ Vaginal Delivery ☐ C- Section Length of pregnancy in weeks: _____ Birth Weight: _____

FEMALE PATIENTS

☐ Not Applicable Age at first period: _____ When was your last period: _____

SOCIAL HISTORY

Parent(s) are : ☐ Married ☐ Divorced ☐ Separated ☐ Single Parent ☐ Other:
Child lives with: ☐ Mother ☐ Father ☐ Stepparent ☐ Foster Parent ☐ Legal Guardian
☐ Siblings Number of Sibling: _____ Does your child live in multiple households: ☐ Yes ☐ No
Do you have any pets: _____
Does anyone living with your child smoke: Tobacco ( ) Yes ( ) No Marijuana ( ) Yes ( ) No
If yes, do they smoke inside the home: ( ) Yes ( ) No
Does your child attend school or childcare: ( ) Yes ( ) No Grade: _____ School: _____

Please list any hobbies/sports your child is interested in: