Providence Medical Group

**Providence Pediatric Subspecialties 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 |
|---|---|---|---|
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| | | | |
| | | | |

**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: