PROVIDENCE Medical Group Southwest Washington

Pediatric Medical History

Child's Name: _____ **Age:** _____ **DOB:** _____

Who child lives with (names): _____

Birth History

1. Birthplace _____
2. Was pregnancy normal? YES NO
3. How many weeks? _____
4. Type of delivery: _____
5. Was delivery normal? YES NO
   If no, please explain: _____
6. Birth weight: _____
7. Birth Length: _____
8. Any nursing problems? YES NO
   If yes, please explain: _____
9. Any pregnancy problems? YES NO
   If yes, please explain: _____

HOSPITALIZATIONS (when/where/why)

_____
_____
_____
_____
_____
_____
_____

SURGERY (date all that apply)

Adenoidectomy_____ Ear Tubes_____
Appendectomy_____ Gastrostomy_____
Circumcision_____ Heart Surgery_____
Cleft Lip_____ Inguinal Hernia_____
Cleft Palate_____ Ear Tubes_____
Lymph Node Biopsy_____ Other_____

Past Medical History

1. Any problems with:

Sleeping	YES	NO
Bedwetting	YES	NO
Weight/Height	YES	NO
Nail Biting	YES	NO
Nightmares	YES	NO
Hearing Problems	YES	NO

2. Eating Habits

Nursed or bottle fed? _____
Use special diets? _____
Taking vitamins? _____
Taking fluoride? _____
Taking medications? _____

3. Contagious Diseases (what age

Measles: _____
Mumps: _____
Rubella (German Measles): _____
Chicken Pox: _____
Scarlet Fever: _____
Any other: _____

4. Travel to a foreign country? YES NO
   If yes, please specify: _____
5. Tuberculosis exposure? _____

Other:

_____
_____
_____

MEDICAL HISTORY: check all that apply

Heart Murmur_____ Hearing Loss_____
ADD/ADHD_____ Seizures_____
Environmental Allergies_____ Strep Throat_____
Asthma_____ HIV/AIDS_____
Cancer _____ Jaundice_____
Pneumonia_____ Lead Poisoning_____
Diabetes Mellitus_____ Obesity_____
Eczema_____ Sickle Cell Anemia____
Vision Problems_____ Headaches_____

Varicella (Chicken Pox)_____ Meningitis____
Inflammatory bowel disease_____ UTI_____
Otitis Media (Ear Infections)_____ Scoliosis_____
Chronic Encephalopathy_____

Other Concerns?_____
_____
Does your child need a referral to a specialist? ____
_____

Please bring a current copy of your child's immunizations to the visit

Please fill in your family medical history with a check mark for anything that applies to you.

Relationship	ALIVE/DECEASED	ARTHRITIS	ASTHMA	BIRTH DEFECTS	CANCER	COPD	DEPRESSION	DIABETES	EARLY DEATH	HEARING LOSS	HIGH BLOOD PRESSURE	HIGH CHOLESTEROL	KIDNEY DISEASE	LEARNING DISABILITY	MENTAL ILLNESS	MENTAL RETARDATION	MISCARRIAGES	STROKE	SUBSTANCE ABUSE	VISION LOSS	OTHER
Mother																					
Father																					
Sister																					
Brother																					
Daughter																					
Son																					
Aunt																					
Uncle																					
Maternal Grandmother																					
Maternal Grandfather																					
Paternal Grandmother																					
Paternal Grandfather																					
Other																					