

PARTNERS IN HEALTH

Pediatric/Adolescent Medical History

Date of Visit ___/___/___

Child's Full Name		DOB ___/___/___	Nickname	Home Phone	
Father		Age	Occupation	Work Phone	
Mother		Age	Occupation	Work Phone	
Stepparent/Guardian		Age	Occupation	Work Phone	
Primary Language in Home:		Daytime Caretaker: <input type="checkbox"/> Day Care Center <input type="checkbox"/> After School Care <input type="checkbox"/> School <input type="checkbox"/> Baby-sitter <input type="checkbox"/> Relative <input type="checkbox"/> None		Telephone Number of Caretaker: 1. _____ 2. _____	
HOUSEHOLD MEMBERS:		Does anyone living with you have a chronic medical problem? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name	Age	Relationship	Name	Age	Relationship
Name	Age	Relationship	Name	Age	Relationship
Name	Age	Relationship	Name	Age	Relationship
CHILD'S HEALTH HISTORY:			OFFICE/PHYSICIAN USE ONLY		
Birth Weight: _____					
Is child adopted: <input type="checkbox"/> Yes <input type="checkbox"/> No					
Any complications with pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Any complications effecting the baby before, during or right after delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has your child missed any regular shots or vaccines? <input type="checkbox"/> Yes <input type="checkbox"/> No					
OPERATIONS AND HOSPITALIZATIONS:					
Has the child had any operations? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the child ever been hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes to either question, please list: _____					

OTHER CONDITIONS OR CONCERNS:					
Has your child had trouble with recurrent illness? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is your child taking any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you have any questions about the development of your child? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does your child have any hearing or vision problems or other disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has your child had any problems with shots/ vaccinations? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is your child allergic to foods, drugs, or other materials? <input type="checkbox"/> Yes <input type="checkbox"/> No					

(OVER PLEASE)

