PAST MEDICAL HISTORY

(Pediatric ≤25 years old)

Patient: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Right or Left hand dominant (Circle) Gender: _____

Family Doctor (Please include phone # and address): _____

_____

Who sent you to this office?: _____

WHY ARE YOU HERE TODAY?: _____

_____

What date did your symptoms start/when did the injury occur?: _____

PAST MEDICAL HISTORY:

Birth History: Weeks at Delivery: _____ Delivery (please circle): Vaginal delivery/C-section

Reason and # of days hospitalized after birth: _____

Age child began walking: _____ Current Height: _____ Current Weight: _____

Major Accidents/Injuries (include dates): _____

Serious childhood illnesses (include hospital stays and dates): _____

_____

PAST SURGICAL HISTORY (include procedure, date, and surgeon): _____

_____

_____

MEDICATIONS (please list name and dose): _____

_____

ALLERGIES: _____

IMMUNIZATIONS: Up-to-date: _____Yes _____No

FAMILY HISTORY (Immediate family members' disease history such as scoliosis, childhood hip problems, diabetes, cancer, bleeding or clotting problems, major reactions to anesthesia, other): _____

_____

SOCIAL HISTORY: School: _____ Grade/Year: _____

Who do you live with?: _____

Interests/Activities: _____

Exercise/Sports/Athletic Participation: _____

PLEASE CIRCLE ANY PROBLEMS LISTED HERE IF YOUR CHILD HAS HAD IT AT ANY TIME

MUSCULOSKELETAL	Heart murmur	**ENDOCRINE**	Previous Cancer	**GYNECOLOGICAL**
Limb or joint pain	Rapid/abnormal pulse	Diabetes	Benign Tumor/Bump	Abnormal periods
Joint swelling	Other/None: _____	Thyroid abnormalities	Other/None: _____	Age periods started _____
Back Pain	**CHEST/RESPIRATORY**	Weak bones/Osteoporosis	**NEUROLOGICAL**	Periods per year _____
Walking problems	Asthma/Chronic Cough	Other/None: _____	History of Concussion(s)	Date of last period _____
Toes turned in/out	Shortness of breath	**GENITOURINARY**	Frequent Headaches	Pregnant now: Yes/No
Bow legs or knock knee	Positive TB test	Incontinence	Fainting or convulsions	Other/None: _____
Juvenile arthritis	Other/None: _____	Kidney/bladder infections	Dizziness or tingling	**SKIN**
Other/None: _____	**EARS/NOSE/THROAT**	Other/None: _____	Diffuse muscle weakness	Rash
ALLERGIC	Neck pain/stiffness	**GASTROINTESTINAL**	Tingling	Other/None: _____
Allergies to medications	Hearing problems	Abdominal Pain	Bowel/bladder control	**CONSTITIUTIONAL**
Seasonal allergies	Sinus problems	Decreased appetite	Other/None: _____	Fever/Chills
Food Allergies	Other/None: _____	Hepatitis	**PSYCHIATRIC**	Night sweats
Other/None: _____	**EYES**	Other/None: _____	Psychiatric care	Weight loss/gain
CARDIOVASCULAR	Vision problems	**HEMATOLOGIC/TUMOR**	History of substance abuse	HIV/Exposure of HIV
High blood pressure	Other/None: _____	Easy bruising/bleeding	Other/None: _____	Other/None: _____

Parent Signature: _____ Provider Signature: _____ Date: _____