

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)

