Pediatric Associates Prof LLC.

Mature Pediatric Medical History Form – (13yrs and up)

Child's Name: _____Birthdate: _____ Today's Date:_____

Medical History

Has your child ever had urinary tract infection? Yes No ~ If yes at what age? _____

Has your child ever been diagnosed with asthma or wheezing? Yes No ~ If yes at what age? _____

Has your child ever had any medical problems? Yes No ~ Specify:_____

_____

Has your child ever had any fractures, concussions, or other serious injury? Yes No ~ Specify (include age):

_____

Does your child have any allergies? Yes No ~ If yes, please specify :_____

Does your child see any specialists? Yes No ~ If yes, who?_____

Has your child ever received Occupational, Physical or Speech therapies? Yes No Explain:_____

Surgeries or hospitalizations (where the patient was admitted to the hospital):

Age: ___Reason:_____Age:___Reason:_____

Family History

Does anyone in your family listed below have any chronic diseases/illnesses…..(like diabetes, heart attacks, strokes, depression, asthma, cancer, thyroid) or any other diseases we should know about? Check alive or deceased. If no health issues, check healthy.

☐Foster Care ☐Adopted

Father: ☐alive ☐deceased ☐healthy ☐other Explain_____

Mother: ☐ alive ☐deceased ☐healthy ☐other Explain_____

Siblings: ☐alive ☐deceased ☐healthy ☐other Explain_____

Father's Father: ☐alive ☐deceased ☐healthy ☐other Explain_____

Father's Mother: ☐alive ☐deceased ☐healthy ☐other Explain_____

Mother's Father: ☐alive ☐deceased ☐healthy ☐other Explain_____

Mother's Mother:☐alive ☐deceased ☐healthy ☐ other Explain_____

Social History

Diet: ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐Diabetic

Exercise: ☐ None ☐ Occasional ☐Moderate ☐ Heavy

Sporting activities: _____ Issues with Bully/Bulling: Yes No

School name: _____ Year in school: _____ Grades in school:_____

Parents' marital status: ☐Married ☐ Unmarried ☐ Separated ☐Divorced ☐ Widowed

Home situation: ☐ Both Parents ☐ Mother ☐ Father ☐Relative ☐ Adopted ☐Foster

Safe at home? Yes No Fluoride in water? Yes No Smoke/CO detectors in home? Yes No

Guns in home? Yes No Guns locked? Yes No Smoke exposure? Yes No ~ Inside Outside

Seat belt or car seat used? Yes No Bike helmets used? Yes No Animal exposure? Yes No

Caffeine intake? Yes No How many drinks per day? _____

Do you smoke? Yes No How much? _____ Chewing tobacco? Yes No

Sexually active? Yes No Number of sexual partners? ____Protected sex? Always Sometimes Never