

**General Pediatric Medical History Form – (3- 12yr old)**

**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 ~ What kind? \_\_\_\_\_**

Does your child see any specialists? **Yes No ~ If yes, who? \_\_\_\_\_**

Has your child ever received Occupational, Physical or Speech therapies? **Yes No ~ \_\_\_\_\_**

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: \_\_\_\_\_ Bully/Bulling: **Yes No**

School name: \_\_\_\_\_ Year in school: \_\_\_\_\_ Grades in school: \_\_\_\_\_

Childcare:  None       Relative       Private Sitter       Daycare       Preschool

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**