# PEDIATRIC PATIENT HISTORY

East Jordan
Family Health Center
601 Bridge Street
East Jordan, MI 49727
(231) 536-2206

Bellaire
Family Health Center
307 E. Cayuga Street
Bellaire, MI 49615
(231) 533-8649

Central Lake
Family Health Center
7960 W. Old State Street
Central Lake, MI 49622
(231) 544-3700

Child/Adolescent's Name: _____ Age Today: ____ Person completing form: _____
Your relationship to the Child: _____

## BIRTH HISTORY:

Date of Birth: _____ Birth weight: _____
Any problems during pregnancy: _____ Any medications during pregnancy: _____
Length of pregnancy : _____ Type of delivery (circle one) Vaginal C-Section
Any problems during delivery: _____ Any problems soon after birth or during hospital stay: _____
Was baby in NICU or observed in Nursery: _____ If yes, why: _____
Baby hospitalized longer than mom: _____ Baby went home with Mom: _____ (check one)

## NEONATAL HISTORY:

Any problems during the first month of life: _____

## PAST HISTORY:

| | | | |
|---|---|---|---|
| _____ Mono | _____ Scarlet Fever | _____ Heart Murmur | _____ Constipation |
| _____ Chicken Pox | _____ Fainting | _____ Meningitis | _____ Diarrhea (2 days) |
| _____ Hives or Rashes | _____ Seizures | _____ Anemia | _____ Joint Pain |
| _____ Fainting | _____ Ear Infection | _____ Asthma or Wheezing | _____ Behavioral Problems |
| _____ Tonsillitis | _____ Bronchitis | _____ Pneumonia | _____ Vomiting (2 days) |
| _____ Bed wetting | _____ Urinary Infection | | |

List major hospitalizations/Emergency Room visits:

Date of Hospitalization Operation or Illness Name of Hospital

_____
_____
_____

Fractures or concussions: _____
(Girls only) Age of 1st Period: _____
List all drugs and food that have caused allergic reactions: _____
_____
List all current **MEDICINES**, dose, and frequency: _____

## FAMILY HISTORY:

Mother's Name: _____ Age: ____ Health problems: _____ Occupation: _____
Father's Name: _____ Age: ____ Health problems: _____ Occupation: _____
Brother: _____ Age: ____ Health problems: _____
Brother: _____ Age: ____ Health problems: _____
Sister: _____ Age: ____ Health problems: _____
Sister: _____ Age: ____ Health problems: _____

Has child/adolescent's grandparents, aunts, uncles or great-grandparents had any of the following:

| | | | | |
|---|---|---|---|---|
| □ High blood pressure | □ Diabetes | □ Tuberculosis | □ Asthma/Allergy | □ Heart Attack before age 40 □ |
| □ Stroke | □ Cancer | □ Seizures | □ Heart disorder | □ Thyroid problems |
| □ Arthritis | □ Kidney Problems | | □ Bleeding Disorder | □ Muscle Disorder |

□ Any Family History of Birth Defects: _____

## SOCIAL HISTORY:

Parents are: (circle one)

Married Never Married Single Separated Divorced Living Together Not Living Together

Preschool Children - Daycare Name: _____ Hours per Week: _____
School-Aged Children - Name of School: _____

Will anyone else bring children to doctor's office in addition to parents: Yes: _____ No: _____
If yes, name of person: _____ relationship to the child: _____

**Please complete consent form.**

_____ _____
Signature of person completing form Date

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