MLK Community Medical Group

Patient Name: _____

Date of Birth: _____

PATIENT HISTORY FORM - PEDIATRIC

Patient Name: _____ Sex: ☐ Male ☐ Female
Last First Middle Initial

Date of Birth: _____ Age: _____ Years _____ Months

Name of Parent or Guardian: _____

Primary Care Physican: _____

REASON FOR VISIT

☐ Routine Check-up

☐ Problem Visit

Please provide a brief description: _____

How long has this been a problem? _____

How severe is this problem? ☐ Mild ☐ Moderate ☐ Severe ☐ Incapacitating

How frequent is the problem? ☐ Constant ☐ Daily ☐ Weekly ☐ Random

Problem is aggravated by: _____

Relieved by: _____

MEDICATIONS

Please list any medications your child is taking, including over-the-counter and prescription medications, vitamins, or herbal medications:

Medication Name & Strength	Dose	How Often	For What Condition

ALLERGIES ☐ Yes ☐ No

Food(s): _____ Reaction: _____

Food(s): _____ Reaction: _____

Food(s): _____ Reaction: _____

Medication(s): _____ Reaction: _____

Medication(s): _____ Reaction: _____

Other: _____ Reaction: _____

Other: _____ Reaction: _____

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CHILD'S BIRTH HISTORY

Birth Weight: _____ lbs, _____ oz Hospital of birth:_____

Mother's age at child's delivery: _____ # of pregnancies: _____ # of living children: _____

Did child's mother have any illnesses or problems during her pregnancy? If yes, please explain: ☐ No ☐ Yes _____

Did child's mother use cigarettes, alcohol, drugs, or any medications (other than vitamins and iron) during pregnancy? ☐ No ☐ Yes _____

Any problems during labor or delivery? ☐ No ☐ Yes _____

Was the baby premature? ☐ No ☐ Yes _____

Age baby went home from hospital: _____

DEVELOPMENTAL HISTORY

At what age did your child:

_____ Rollover
_____ Sit alone
_____ Walk alone
_____ Say first words
_____ Speak two-word sentences
_____ Toilet trained

Serious Illnesses, Injuries, Hospitalizations and Surgeries:

Year	Illness/Injury/Hospitalization/Surgery	Hospital, City, State

Additional Physicians/Health Care Providers who care for your child:

Name	Specialty	Contact Information

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PATIENT HISTORY FORM - PEDIATRIC

FAMILY MEDICAL PROBLEMS: Please identify any medical problems blood relatives have or have ever had:

Condition	Yes	No	Family Member(s)	Condition	Yes	No	Family Member(s)
Birth Defects	☐	☐		Kidney disease	☐	☐	
Inherited family diseases	☐	☐		Diabetes	☐	☐	
Childhood deaths	☐	☐		Thyroid disease	☐	☐	
Mental Retardation	☐	☐		Anemia/Blood disorders	☐	☐	
Seizures/Convulsions	☐	☐		Bone/ Joint disorders	☐	☐	
Mental disease/disorder	☐	☐		Rheumatoid Arthritis	☐	☐	
Autism	☐	☐		Muscle disorders	☐	☐	
ADD/ADHD	☐	☐		Skin disease	☐	☐	
Eye or Ear disorders	☐	☐		Cancer	☐	☐	
Allergies, Hay Fever, Eczema	☐	☐		Rheumatic Fever	☐	☐	
Asthma	☐	☐		Tuberculosis	☐	☐	
Heart Disease	☐	☐		Venereal Disease	☐	☐	
Elevated Cholesterol	☐	☐		HIV/AIDS	☐	☐	
Heart Attack at age <50 years	☐	☐		Smoke regularly	☐	☐	
High Blood Pressure	☐	☐		Other: _____	☐	☐	
Stomach, Intestinal problems	☐	☐		Other: _____	☐	☐	

SOCIAL HISTORY

Race: _____ Ethnicity: _____

Preferred Language: _____ Need Interpreter? ☐ No ☐ Yes

Mother's Name: _____ Age: _____ Occupation: _____

Father's Name: _____ Age: _____ Occupation: _____

Parents are: ☐ Married ☐ Not Married ☐ Separated ☐ Divorced ☐ Deceased

Child lives with: ☐ Mother ☐ Father ☐ Siblings ☐ Others (*please list below*)

Others in Home: _____

_____

_____

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FAMILY MEDICAL PROBLEMS: Has your child had or now have any of the following:

	No	Yes	Doctor's Notes
INFECTION			
Measles (10 Days), Mumps	☐	☐	
Rubella (3 days measles)	☐	☐	
Chicken Pox	☐	☐	
Whooping Cough	☐	☐	
Hepatitis	☐	☐	
EYES			
Crossed or wandering eyes	☐	☐	
Vision problems	☐	☐	
Recurrent infection, Pink Eye	☐	☐	
EARS			
Frequent ear infections, ear tubes	☐	☐	
Hearing problems	☐	☐	
Difficulty talking	☐	☐	
Stuttering	☐	☐	
MOUTH			
Been to a dentist	☐	☐	
Date of last visit:			
Dental problems	☐	☐	
Nose and throat problems	☐	☐	
Frequent sore throats or tonsil infection	☐	☐	
Persistent hoarseness	☐	☐	
Frequent nose bleeds	☐	☐	
Frequent stuffed up nose/nasal allergies	☐	☐	
Tendency to breathe through his/her mouth	☐	☐	
LUNGS			
Tendency to wheeze, history of asthma	☐	☐	
Repeated coughing spells, or chronic cough	☐	☐	
Pneumonia, Bronchitis	☐	☐	
HEART			
Heart Murmur	☐	☐	
Irregular Heartbeat	☐	☐	
High Blood Pressure	☐	☐	
Abnormal Cholesterol test	☐	☐	
NERVOUS SYSTEM			
Dizzy or fainting spells	☐	☐	
Convulsion, Seizures	☐	☐	
Difficulty walking, balancing, or handling objects	☐	☐	
Frequent headaches	☐	☐	
Attention Deficit Disorder	☐	☐	
MUSCULOSKELETAL SYSTEM			
Painful/swollen joints	☐	☐	
Sprains/dislocations, or broken bones	☐	☐	
Posture problems, Scoliosis	☐	☐	
Muscle coordination or strength problems	☐	☐	

	No	Yes	Doctor's Notes
SKIN			
Slow-healing bruises	☐	☐	
Persistent rashes	☐	☐	
DIGESTIVE SYSTEM			
Frequent stomach aches	☐	☐	
Frequent diarrhea	☐	☐	
Frequent constipation	☐	☐	
Frequent nausea/vomiting	☐	☐	
Worms, parasites	☐	☐	
Bloody or black stools	☐	☐	
A special diet or food restriction	☐	☐	
Ulcers	☐	☐	
GENITOURINARY SYSTEM			
Painful, burning urination	☐	☐	
Blood in urine	☐	☐	
Bed-wetting problems	☐	☐	
Bladder or kidney infection	☐	☐	
Discharge from vagina or penis	☐	☐	
Menstrual periods (girls)	☐	☐	
Age of onset:			
GENERAL			
Anemia/blood disorder	☐	☐	
Excess thirst	☐	☐	
Marked in/decrease in appetite	☐	☐	
Unusual sensitivity to cold or heat	☐	☐	
Eaten paint, dirt, plaster	☐	☐	
Been persistently tired	☐	☐	
Unusually slow-healing scrapes, cuts, wounds	☐	☐	
Recurrent fevers	☐	☐	
Taken medication for more than 3 months	☐	☐	
Within the past 6 months has your child:	☐	☐	
Had frequent nightmares	☐	☐	
Been usually nervous	☐	☐	
Has persistent sadness	☐	☐	
Been unusually disobedient	☐	☐	
Been having problems with friends in school	☐	☐	
Other *(please describe)*	☐	☐	