Piper Family Medicine, PC

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Pediatric Medical History Form

Patient Name:_____ Birth Date:_____ Today's Date:_____

Personal Medical History: (Please include even if under control with medication)			
	Yes	No	Comments
Diabetes			
High Blood Pressure			
Liver Problems			
Kidney Problems			
Heart Disease (specify)			
Asthma			
ADD/ADHD			
Chronic Ear/Throat Problems			
Other (specify)			

Vaccinations: (Please provide copy of vaccinations received.)
Child has up to date vaccinations: ☐ Yes ☐ No

For Girls:
Has she started her period? ☐ Yes ☐ No
Age started:_____

Current Medications and Dosages:

_____
_____
_____
_____
_____

Medication Allergies and Reactions:

_____
_____
_____
_____
_____

Surgical/Procedural History and Dates:

_____
_____
_____

_____
_____
_____

Social History:
School:_____Grade:_____
Activities:_____
Exercise (how many hours per week): _____
Behavioral Problems:_____
Second Hand Smoke Exposure: ☐ Yes ☐ No

Family Medical History: Please list any major ongoing medical problems (specifically high blood pressure, heart disease, stroke, diabetes, cancer and any other pertinent conditions), and if applicable, age at death and cause of death.

Mother:

_____
_____
_____

Mother's side of the family:

_____
_____
_____

Father:

_____
_____
_____

Father's side of the family:

_____
_____
_____

Siblings:

_____
_____

Review of Systems:			
Do you have problems with?	Yes	No	Please explain
Head			
Eyes			
Ears			
Nose			
Throat			
Neck			
Chest/Lungs			
Stomach			
Kidneys/Bladder			
Bowels			
Reproductive Organs			
Arms/Hands			
Legs/Feet			
Muscles/Joints			
Skin			
Back/Spine/Nerves			
Others			
Main Objective of Today's Visit: Out of all of your health questions and concerns, what would you like to be addressed most with today's visit?			