Associates in Pediatric and Adolescent Medicine

PATIENT HISTORY

PATIENT'S NAME: ____ Date of birth: ________________

Referred by: _______________________________________ Previous Doctor: ________________________

Birth Weight: __________ lbs. __________oz. (Circle One) Vaginal Delivery C/S Adopted

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Past Medical History

Hospitalizations	Y	N	Surgeries	Y	N
Serious Accidents	Y	N	Fractures	Y	N
Hay Fever/Sinus/Allergy	Y	N	Asthma/Wheezing	Y	N
Seizures	Y	N	Chicken Pox	Y	N
Vision Problems	Y	N	Hearing Problems	Y	N
Heart Murmur	Y	N	Recurrent Ear Infections	Y	N
Learning Problems	Y	N	Depression	Y	N

Please explain **ALL Yes** answers and other conditions:

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Medication/Drug allergies: __________________________________ Dietary Restrictions: ______________

Current Medications: ____

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Immunizations Up to Date? __________ Grade (School) ____

Family History

Allergic Rhinitis/Hay Fever/"Sinus"	Y	N	Asthma	Y	N
Atherosclerosis (Cholesterol > 240)	Y	N	Hypertension	Y	N
Diabetes	Y	N	Lazy Eye (Strabismus)	Y	N
Hearing Problems (Congenital)	Y	N	Seizures	Y	N
Kidney Disease	Y	N	Bleeding Problems	Y	N
Migraine Headaches	Y	N	Mental Illness	Y	N
Depression	Y	N	Anxiety	Y	N

Learning Problems (ADHD/ Processing/Dyslexia)	Y	N
Heart Attacks (MI) Strokes (CVA)/Heart Problems under 55 years	Y	N

Please explain **ALL Yes** answers:

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Social History

Pets? Y N if so, what kind? ___________________________ Smokers in home? Y N

Patient lives with ☐Both Parents ☐ Mother ☐Father ☐ other: