Northwest PRIMARY CARE

Pediatric Medical History Form

Legal Name: _____ DOB: _____ Date: _____

Preferred Name: _____ Pronoun(s): _____ Gender: _____

Who lives in the child's household?
Any other adults involved in the child's care?
List allergies/intolerances to medications:

Personal Medical History: Check Yes or No, explain yes answers (when occurred or was diagnosed)				
Alcoholism	Y	○	N	○
Anxiety Disorder	Y	○	N	○
Anemia	Y	○	N	○
Arthritis	Y	○	N	○
Asthma	Y	○	N	○
Bleeding tendency	Y	○	N	○
Blood clot	Y	○	N	○
Cholesterol (high)	Y	○	N	○
Cancer	Y	○	N	○
Depression	Y	○	N	○
Diabetes	Y	○	N	○
Emphysema/COPD	Y	○	N	○
Epilepsy	Y	○	N	○
Exposure to asbestos	Y	○	N	○
Exposure to TB	Y	○	N	○
Glaucoma	Y	○	N	○
Hayfever	Y	○	N	○
Heart disease	Y	○	N	○
Hepatitis (yellow jaundice)	Y	○	N	○
High blood pressure	Y	○	N	○
Kidney disease	Y	○	N	○
Kidney stone	Y	○	N	○
Migraines	Y	○	N	○
Osteoporosis	Y	○	N	○
Pneumonia	Y	○	N	○
Polio	Y	○	N	○
Recurrent bladder infection	Y	○	N	○
Rheumatic fever	Y	○	N	○
Sleep Apnea	Y	○	N	○
Stroke	Y	○	N	○
Thyroid disease	Y	○	N	○
Tuberculosis	Y	○	N	○
Ulcer	Y	○	N	○
Other serious illness	Y	○	N	○

Please list all surgeries with dates.	
Surgery	Date:

Adopted?	Y	○	N	○
Foster Child?	Y	○	N	○

Family History (Blood Relatives)		
If living, list any health problems (heart disease, cancer, diabetes, high blood pressure, etc.). If deceased, cause of death.		**Age at Death**
Father		
Mother		
Maternal Grandparents		
1		
2		
Paternal Grandparents		
1		
2		
Brothers and Sisters		
1		
2		
3		
4		
5		

Family Medical: Place a check next to each condition a family member has had.			
ADD/ADHD	○	Eczema	○
Allergies	○	Genetic Disorder	○
Anemia	○	Heart Problems	○
Asthma	○	High Cholesterol	○
Birth Defects	○	High Blood Pressure	○
Blood Disorder	○	Intellectual Disability	○
Cancer	○	Learning Disability	○
Curved Spine	○	Mental Illness	○
Deafness	○	Migraines	○
Depression	○	Obesity	○
Developmental Delay	○	Seizure Disorder	○
Diabetes	○	Sudden Infant Death	○
Drug/alcohol abuse	○	Thyroid Disease	○
Other:			

Safety				
Is there a smoke alarm in the home?	Y	○	N	○
Carbon monoxide alarm in the home?	Y	○	N	○
Guns in the household?	Y	○	N	○
Secondhand tobacco smoke?	Y	○	N	○
Prescription pain meds in the home?	Y	○	N	○
Marijuana or other drug use in the home?	Y	○	N	○

Meds				
Any daily over-the-counter medications?	Y	○	N	○
If Yes, which ones?				
1				
2				
3				
4				

FORM CONTINUES ON THE OTHER SIDE

PEDIATRIC HISTORY QUESTIONNAIRE

For children up to 3 years old

Delivery/Newborn Period:				**Birth History: During pregnancy, did mother**				
Delivery Type	Vaginal ○	C-Section ○		Smoke?	Y ○	N ○	
Birth Weight:				Drink alcohol?	Y ○	N ○	
Problems in Newborn Period:				Use Drugs/Medications?	Y ○	N ○	
				Experience illness?	Y ○	N ○	

Please explain any YES answers:

For children to 3 to 9 years old

Where does your child go to school?	What grade?		
Has your child repeated or been held back a grade?	Y ○	N ○	
Has your child attended a special class?	Y ○	N ○	
Does your child have behavior problems at school?	Y ○	N ○	
Has your child had any bullying problems?	Y ○	N ○	
How much screen time (video, TV, computer, phone) during a typical day?	Hours per day:		

Please explain any YES answers:

For children 10 to 12 years old

Where does your child go to school?	What grade?		
Has your child repeated or been held back a grade?	Y ○	N ○	
Has your child attended a special class?	Y ○	N ○	
Does your child have behavior problems in school?	Y ○	N ○	
Has your child had any bullying problems?	Y ○	N ○	
Any academic problems?	Y ○	N ○	
How much screen time (video, TV, computer, phone) during a typical day?	Hours per day:		
Any concerns about body image?	Y ○	N ○	

Please explain any YES answers:

For children 13 to 18 years old (Patient to Complete)

Where do you go to school?	What grade?				
Do you have behavior problems in school?	Y ○	N ○			
Have you had any bullying problems?	Y ○	N ○			
Any academic problems?	Y ○	N ○			
How much screen time (video, TV, computer, phone) during a typical day?	How many hours?				
Any concerns about body image?	Y ○	N ○			
Concerns about sexuality?	Y ○	N ○			
Do you use alcohol?	Y ○	N ○			
Do you use tobacco?	Y ○	N ○			
Do you use caffeine, coffee, tea, soda, power drinks?	Y ○	N ○			
Do you use “recreational drugs”?	Y ○	N ○			
Are you sexually active?	Yes ○	Not Currently ○	Never Have ○		
What gender(s) are you attracted to?			Not Sure ○		
Would you like to talk about sexual health topics or gender identity today?	Y ○	N ○			
Do you see a dentist?	Y ○	N ○			
If Yes list dentist name:					
Any concerns for depression or anxiety?		Y ○	N ○		
Have you ever been abused?	N ○	Physically ○	Mentally ○	Sexually ○	
Are you satisfied with your weight?	Y ○	N ○			
What do you do for exercise?					
How often do you exercise?					
Do you always wear a seat belt?	Y ○	N ○			
If you ride a bike or motorcycle, do you always wear a helmet?	Y ○	N ○			
Are guns kept in your home?	Y ○	N ○			
If yes, is the household aware of gun safety?	Y ○	N ○			

Please explain any YES answers

Practitioner: _____ Date: _____

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