MEDICE PRIMARY CARE

Pediatric New Patient Medical History Form

Last Name:	First Name:	Preferred Name:
Today's Date:	Date of Birth:	Gender: ☐ Male ☐ Female
School:	Grade:	
Mother's Name:	Father's Name:	
Mother's Occupation:	Father's Occupation:	
Child Lives With: ☐ Both ☐ Mother ☐ Father ☐ Other:		

If child does not live with parents how often does he/she get to see parents:

Name of any specialist your child sees, the reason and last seen date:

Household		
Please list all those living in the child's home (parents, siblings, grandparents, etc...)		
Name	**Relationship to Child**	**Birth Date**
Any Pets living in house with child?	☐ YES	☐ NO
If yes, how many and what kind?		
Any guns in house?	☐ YES	☐ NO
Do parents smoke?	☐ YES	☐ NO
Any household member use alcohol or drugs?	☐ YES	☐ NO

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Patient Name: DOB:

Birth History

Birth Weight: _____ lb _____ oz

Was the baby born at (Circle one): Term Early Late

If early how many weeks gestation: _____

Where was baby born? _____

Did baby go home with mom: ☐ YES ☐ NO

Explain: _____

Was the delivery: ☐ Vaginal ☐ Cesarean

If cesarean why? _____

Did your baby have any problems immediately after birth:
☐ YES ☐ NO
If yes explain: _____

Was initial feeding after birth: ☐ Breast ☐ Bottle
Did baby go home with mom: ☐ YES ☐ NO
Explain: _____

Did mother have any illnesses during or problems with pregnancy: ☐ YES ☐ NO
If yes, explain:

_____

During pregnancy did mother take any of the following?

Smoke: ☐ YES ☐ NO If yes how much: _____

Drink Alcohol: ☐ YES ☐ NO If yes, what; how often; how many: _____

Drugs/Medications: ☐ YES ☐ NO If yes what and how often: _____

Feeding And Nutrition:	YES	NO
Is your child's appetite good?		
Did your child suffer from colic in first three months?		
Does your child take Vitamins or herbal supplements?		
Is your child a picky eater?		
Developmental:	**YES**	**NO**
Are you concerned about your child's physical development?		
Are you concerned about your child's emotional development?		
Are you concerned about your child's attention span?		
Does your child have trouble sleeping?		
Does your child get along with other children?		
Did your child say any words by 1½ years old?		

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Food Insecurities

In the last 12 months, I worried whether my food would run out before I got money to buy more.

☐ Often true ☐ Sometimes true ☐ Never true ☐ Declines/Unable to Answer

In the last 12 months, the food I bought just didn't last and I didn't have money to buy more.

☐ Often true ☐ Sometimes true ☐ Never true ☐ Declines/Unable to Answer

Allergies to Medications/Environmental

Please list any medications/foods/insect bites that has had any type of reaction to or is allergic to:

Medication/Food/Insect Bites Allergy	Reaction

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Family Medical History:

Condition	Mother	Father	Sibling	Grandparent
Alcohol Abuse				
Anemia				
Asthma/Reactive Airway Disease				
Autoimmune Disorder				
Bed Wetting (after age 10)				
Bleeding Disorder				
Congenital Deafness				
Diabetes (Before age 50)				
Drug Abuse				
Epilepsy or Convulsions				
Heart Disease (Before age 50)				
High Blood Pressure (Before age 50)				
High Cholesterol				
Immune Disorder				
Immune Problems (HIV/AIDS)				
Kidney Disease				
Liver Disease				
Lupus				
Mental Illness				
Mental Retardation				
Nasal Allergies				
Tuberculosis				
Other:				

Medication History			
Please list any medications your child takes daily:			
Medication	**Strength**	**Times a Day**	**Reason**

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Child's Past Medical History:

Condition	Yes	No	Explanation
Abdominal Pain			
Anemia, Bleeding Problems, blood transfusion			
Anxiety/Depression/ADHD/other			
Asthma, Bronchitis, Bronchiolitis, pneumonia			
Bed Wetting (after age 5)			
Bladder/Kidney Problems			
Bowel Problems/ Constipation			
Chicken Pox			
Chronic / Recurrent Skin Problems (acne, eczema, etc.)			
Concussion/ Head injury			
Developmental delay			
Diabetes			
Ear Problems			
Eating Disorder			
Eye Problems			
Headaches			
Heart Problems			
Mental Illness			
Mental Retardation			
Nasal Allergies			
Neurological problems (Convulsions, seizures, etc.)			
Recurrent infections			
Resource class/special ed			
Thyroid			
For Girls: Menstrual Period Began?			
Use of drugs / alcohol			
Other:			

Surgeries	
Please indicate any surgeries/ hospitalizations your child has had:	
Type of surgery	Date of Surgery

Patient or Parent/Legal Guardian (if patient is considered an incapacitated minor) (signature) _____ Date _____

Witness Signature _____ Print Name _____ Date _____ Time _____