**Columbus Medical Clinic Pediatric Medical History Form**

Patient Name: Date of Birth: Today’s Date:

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| ***ALLERGIES*** | | | | | | | | |
| Allergies: No Yes, please list | | | | | | | | |
| ***CURRENT MEDICATIONS* (include over the counter medications, herbals, supplements, etc.)** | | | | | | | | |
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| ***BIRTH HISTORY (For Newborns – Age 10)*** | | | | | | | | |
| Birth Weight: lbs ounces inches Place of Birth (Hospital Name: | | | | | | | | |
| Term Pregnancy? Yes No  If no, how many weeks preterm? | | | | | Delivery: Vaginal (natural) C-Section Complications with delivery? Yes No  If yes, please explain: | | | |
| ***PERSONAL/FAMILY MEDICAL HISTORY*** | | | | | | | | |
|  | **Personal History** | | | **Family History** | | | | |
| Allergies Asthma  Cancer, Types |  |  | Yes No  Yes No  Yes No |  | Yes No  Yes No  Yes No | Family member: Family member:  Family member: | | |
| CVA (Stroke)  Diabetes Mellitus Glaucoma |  |  | Yes No  Yes No  Yes No |  | Yes No  Yes No  Yes No | Family member:  Family member: Family member: | | |
| Heart Disease |  |  | Yes No |  | Yes No | Family member: | | |
| High Blood Pressure |  |  | Yes No |  | Yes No | Family member: | | |
| High Cholesterol Kidney Disease  Rheumatic Fever |  |  | Yes No  Yes No  Yes No |  | Yes No  Yes No  Yes No | Family member: Family member:  Family member: | | |
| Tuberculosis (TB) |  |  | Yes No |  | Yes No | Family member: | | |
| Other: |  |  | Yes No |  | Yes No | Family member: | | |
| Environmental Exposure |  |  | Yes No |  | |  | | |
| ***HOSPITALIZATIONS*** | | | | | | | | |
| **Reason for Hospitalization** | | | **Date of Hospitalization** | | | | | **Hospital/Physician** |
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| ***SURGICAL HISTORY*** | | | | | | | | |
| **Type of Surgery** | | | **Date of Surgery** | | | | | **Hospital/Physician** |
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| ***SOCIAL HISTORY*** | | | | | | | | |
|  | **Alive?** | | **Birth Year** | **Age at Death** | | **Cause of death** | | |
| Father | Yes No | |  |  | |  | | |
| Mother | Yes No | |  |  | |  | | |
|  | | | | | | | | |
|  | **How many?** | | **# Alive** | **Birth Year(s)** | | | **If deceased, age and cause of Death** | |
| Brother(s) |  | |  |  | | |  | |
| Sister(s) |  | |  |  | | |  | |
|  | | | | | | | | |
| Parent’s Marital Status: | | Single Married Separated Divorced Widowed | | | | | | |
| Members of Household:  (please check all that apply) | | Parents Mother Stepmother Father Stepfather brother(s) sister(s) Grandparent Foster parents | | | | | | |
| Tobacco Smoke Exposure: | | Yes No If yes, who? | | | | | | |
| Daycare/School: | | Grade Level: School: | | | | | | |
| Hobbies/Recreation:  (please list) | |  | | | | | | |
| ***IMMUNIZATIONS*** | | | | | | | | |
| Date of Last Tetanus: Date of Last Flu Vaccine: | | | | | | | | |
| ***OTHER MEDICAL PROVIDERS*** | | | | | | | | |
| Name: | | | | | Specialty: | | | Phone No.: |
| Name: | | | | | Specialty: | | | Phone No.: |
| Name: | | | | | Specialty: | | | Phone No.: |

Signature: Printed Name: Date: