**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 NoIf no, how many weeks preterm?  | Delivery: Vaginal (natural) C-Section Complications with delivery? Yes NoIf yes, please explain:  |
| ***PERSONAL/FAMILY MEDICAL HISTORY*** |
|  | **Personal History** | **Family History** |
| Allergies AsthmaCancer, Types  |  |  | Yes NoYes NoYes No |  | Yes NoYes NoYes No | Family member: Family member: Family member:  |
| CVA (Stroke)Diabetes Mellitus Glaucoma |  |  | Yes NoYes NoYes No |  | Yes NoYes NoYes 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 DiseaseRheumatic Fever |  |  | Yes NoYes NoYes No |  | Yes NoYes NoYes 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** |
|  |  |  |
|  |  |  |
|  |  |  |
| ***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: