**Family Medicine Associates of Midland, P.C.**
**Pediatric Health History**

Today's Date:_____

Patient's Full Name:_____ Birth Date:_____ Marital Status of Parents
Mother: _____ Father:_____ [ ] S [ ] M [ ] W [ ] Sep
Address:_____ City/State/Zip_____
Phone # Home:_____ Father Work_____ Mother Work_____
Employer/Occupation – Father_____ Mother_____
Insurance_____

**Today's Visit**
Reason/Problem_____ Location_____
How long has the child had this problem?_____
How severe is the problem? [ ] mild [ ] moderate [ ] very
What caused this problem?_____
Do you know of anything else that may have contributed to this problem?_____
Does anything else occur with this problem?_____

**Describe Hospitalizations/Surgeries/Serious Injuries** **When?**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies:
1._____
2._____
3._____
4._____

Current Medications:
1._____
2._____
3._____
4._____

**Social History**
Pets:_____
School Attending/Current Grade:_____
Hobbies, interests:_____
_____

Immunizations given at:
[ ] Health Dept. [ ] Doctor's office

**Family Medical History**

| | Age | Diseases | If Deceased, Cause of Death |
|---|---|---|---|
| Father | ____ | _____ | _____ |
| Mother | ____ | _____ | _____ |
| Siblings | ____ | _____ | _____ |
| | ____ | _____ | _____ |
| | ____ | _____ | _____ |
| | ____ | _____ | _____ |
| Father's Father | ____ | _____ | _____ |
| Mother | ____ | _____ | _____ |
| Mother's Father | ____ | _____ | _____ |
| Mother | ____ | _____ | _____ |

Other major illnesses in the family?_____
_____

Provider Comments: [ ] I have confirmed the above information with the patient/parent, the following are additional comments:_____

**~Please flip page for more questions~**

Please answer all questions

Has your child recently experienced:

**Constitutional** — **When?**

Good General Health.....No Yes _____
Recent weight change.....No Yes _____
Fever.....No Yes _____
Fatigue.....No Yes _____
Headaches.....No Yes _____

**Eyes**

Eye disease or injury.....No Yes _____
Wear glasses/contact lens...No Yes _____
Blurred or double vision....No Yes _____

**Ears, nose and throat**

Hearing Loss.....No Yes _____
Ringing in the ears.....No Yes _____
Earaches or drainage.....No Yes _____
Sinus infections.....No Yes _____
Frequent nose bleeds.....No Yes _____
Frequent mouth sores.....No Yes _____
Bad breath or bad taste.....No Yes _____
Sore throat or voice change..No Yes _____

**Cardiovascular**

Chest pain.....No Yes _____
Sudden heart beat changes...No Yes _____
Dizziness/passing out
with exercise.....No Yes _____

**Respiratory**

Frequent coughing.....No Yes _____
Shortness of breath.....No Yes _____
Asthma or wheezing.....No Yes _____

**Gastrointestinal**

Loss of appetite.....No Yes _____
Nausea or vomiting.....No Yes _____
Frequent diarrhea.....No Yes _____
Painful BM or constipation...No Yes _____
Blood in stool.....No Yes _____
Stomach pain.....No Yes _____

**Genitourinary**

Frequent urination.....No Yes _____
Burning/painful urination.....No Yes _____
Blood in urine.....No Yes _____
Incontinence/dribbling.....No Yes _____
Bed wetting/accidents.....No Yes _____

**Musculoskeletal** — **When?**

Joint Pain.....No Yes _____
Weakness of muscles or joints.....No Yes _____
Muscle pain or cramps.....No Yes _____
Back Pain.....No Yes _____
Difficulty walking.....No Yes _____

**Skin**

Rash or itching.....No Yes _____
Change in hair or nails.....No Yes _____

**Neurological**

Frequent or recurring headaches.....No Yes _____
Light-headed or dizzy.....No Yes _____
Convulsions or seizure.....No Yes _____
Numbness or tingling sensations.....No Yes _____

**Psychiatric**

Memory loss or confusion.....No Yes _____
Nervousness.....No Yes _____
Depression.....No Yes _____
Sleep problems.....No Yes _____

**Endocrine**

Glandular or hormonal problem.....No Yes _____
Thyroid disease.....No Yes _____
Excessive thirst or urination.....No Yes _____
Sleep problems.....No Yes _____

**Hematological/Lymphatic**

Slow to heal after cuts.....No Yes _____
Easily bruise or bleed.....No Yes _____
Anemia.....No Yes _____
Persistently enlarged glands.....No Yes _____

**Exposure to:**

[ ] others with chronic cough
[ ] nursing homes
[ ] recent immigrants
[ ] international travel

_____
Parent/Legal Guardian Signature

_____
I have reviewed and confirmed this information
with patient/parents