MADDERN SIMONSEN

Pediatric Medical History Form

Today's Date: ____ / ____ /____

PATIENT NAME: Please Print

____
(First Name) (M) (Last Name)

DATE OF BIRTH: ____ / ____ /____ **Name of patient's physician:** ____________________

Name of doctor that sent you here (if different than above) ____________________

I. Reason for Visit: ____________________

II. Medication History

Pharmacy: ____________________

Prescription drugs your child takes now: ☐ None

____
____
____
____
____
____
____

Over the counter medications your child takes now:

☐ None

☐ Aspirin ☐ Ibuprofen

☐ Other pain medicine, Name: ____________________

☐ Nasal spray, Name: ____________________

☐ Allergy pill, Name: ____________________

☐ Antacid pill, Name: ____________________

☐ Others: ____________________

III. Medical History: ☐ None

☐ Congenital heart disease ☐ Easy bleeding or bruising problems ☐ Prematurity

☐ Anesthesia problems ☐ Asthma ☐ Sleep apnea

☐ Reflux or easy vomiting ☐ Did not pass newborn hearing screening

☐ Diagnosed syndrome: ____________________

☐ Other health conditions: ____________________

IV: Allergies:

i. **Does your child have any allergies to drugs or medications:** ☐ **Yes** ☐ **No**

If yes, list medication and reaction: ____________________

ii. **Does your child have any environmental, food or latex allergies:** ☐ **Yes** ☐ **No**

If yes, list allergy and reaction: ____________________

V. Surgical History: Has your child undergone any surgery? ☐ **Yes** ☐ **No**

If yes, list:

______________________________ Date: ______________________________

______________________________ Date: ______________________________

______________________________ Date: ______________________________

VI. Family History: Has anyone in your family have or had any of the listed problems? ☐ **None** ☐ **Family History Unknown**

☐ Anesthesia problems Who: ______________________________

☐ Easy bleeding or bruising problems Who: ______________________________

☐ History of frequent ear infections Who: ______________________________

☐ Hearing loss Who: ______________________________

☐ Environmental allergies Who: ______________________________

VII: Social History:

1. Parental tobacco use: Do the parents or primary care givers smoke? ☐ Yes ☐ No

If yes,

i. **Who smokes?** ☐ Mother ☐ Father ☐ Both parents ☐ Other

ii. **Is tobacco use inside or outside the home?** ☐ Inside ☐ Outside ☐ Both

iii. **Is tobacco used around children?** ☐ Yes ☐ No

2. Is the child in daycare? ☐ Yes ☐ No

3. Are there any pets with hair or dander at home? ☐ Yes ☐ No

If yes, list______________________________

VIII. Review of Symptoms: Check box for problems your child has **now.** If no problems in that area now, check "no problems".

Ear Nose Throat (ENT)

☐ NO PROBLEMS
☐ Ear pain
☐ Hearing loss
☐ Snoring
☐ Mouth breathing
☐ Nasal congestion
☐ Sore throat
☐ Hoarseness
☐ Lump in neck
☐ Weak cry

Genitourinary

☐ NO PROBLEMS
☐ Kidney problems

Constitutional

☐ NO PROBLEMS
☐ Fever
☐ Fatigue

Endocrine

☐ NO PROBLEMS
☐ Diabetes

Lungs

☐ NO PROBLEMS
☐ Shortness of breath
☐ Wheezing
☐ Noisy breathing

Heart

☐ NO PROBLEMS
☐ Murmur
☐ Congenital heart disease

Neurologic

☐ NO PROBLEMS
☐ Seizures
☐ Weakness
☐ Developmental delay

Digestive

☐ NO PROBLEMS
☐ Swallowing problems
☐ Choking

Eyes

☐ NO PROBLEMS
☐ Blindness
☐ Double vision
☐ Eye pain

Blood

☐ NO PROBLEMS
☐ Anemia
☐ Bleeding or bruising easily

Skin

☐ NO PROBLEMS
☐ Hives
☐ Itching