Arrow
FAMILY MEDICINE

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PEDIATRIC PATIENT HISTORY

Patients Name: ______________________ **DOB:** ______________ **Today's Date:** ______________

COMPLAINTS/CONCERNS

For what reason are you here today? ____

Describe your child's strengths (physical and/or emotional):

Describe your child's weaknesses (physical and/or emotional):

HPI

Allergies or intolerance to drugs or other substances:	Reaction:
______________________	______________________
______________________	______________________
______________________	______________________

Current medications:	Dose / Times per day you take them:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Please check all conditions that apply:

GASTROINTESTINAL
- ☐ Irritable Bowel Syndrome
- ☐ Inflammatory Bowel Disease
- ☐ Crohn's
- ☐ Ulcerative Colitis
- ☐ Gastritis
- ☐ GERD (reflux)
- ☐ Celiac Disease

CARDIOVASCULAR
- ☐ Heart Disease
- ☐ Elevated Cholesterol
- ☐ High Blood Pressure
- ☐ Rheumatic Fever
- ☐ Mitral Valve Prolapse

GENITAL AND URINARY SYSTEMS
- ☐ Kidney Stones
- ☐ Urinary Tract Infections
- ☐ Yeast Infections

METABOLIC/ENDOCRINE
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Hypoglycemia
- ☐ Metabolic Syndrome
- ☐ Low thyroid
- ☐ Overactive thyroid
- ☐ Endocrine Problems
- ☐ Polycystic Ovarian Syndrome
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Frequent Weight Fluctuations
- ☐ Bulimia
- ☐ Anorexia
- ☐ Binge Eating Disorder
- ☐ Night Eating Disorder
- ☐ Eating Disorder (non-specific)

CANCER
- ☐ ______________________

MUSCULOSKELETAL/PAIN
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Pain

INFLAMMATORY/AUTOIMMUNE
- ☐ Chronic Fatique Syndrome
- ☐ Autoimmune Disease
- ☐ Lupus SLE
- ☐ Immune Deficiency Disease
- ☐ Severe Infectious Disease
- ☐ Frequent Infections
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Multiple Chemical Sensitivities
- ☐ Latex Allergy

SKIN DISEASES
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne

RESPIRATORY DISEASES
- ☐ Ear Infections
- ☐ Upper Respiratory Infections
- ☐ Asthma
- ☐ Chronic Sinusitis
- ☐ Bronchitis
- ☐ Sleep Apnea

NEUROLOGIC/MOOD
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Headaches
- ☐ Migraines
- ☐ ADD/ADHD
- ☐ Sensory Integrative Disorder
- ☐ Autism
- ☐ Mild Cognitive Impairment
- ☐ Multiple Sclerosis
- ☐ Seizures

OTHER ____

PREVIOUS EVALUATIONS

Please indicate when you had the following preventative tests and services:

- ☐ Full Physical Exam
- ☐ Psychological Evaluation
- ☐ Speech and Language Evaluations
- ☐ Genetic Evaluations
- ☐ Gastroenterology Evaluations
- ☐ Celiac/Gluten Testing
- ☐ Allergy Evaluation
- ☐ Auditory Evaluation
- ☐ Vision Evaluation
- ☐ Osteopathic
- ☐ Acupuncture
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Sensory Integration Therapy
- ☐ Language Classes
- ☐ Sign Language
- ☐ Homeopathic
- ☐ Naturopathic
- ☐ Craniosacral
- ☐ Chiropractic
- ☐ MRI
- ☐ CT Scan
- ☐ Upper Endoscopy
- ☐ Upper GI Series
- ☐ Ultrasound

SURGERIES / INJURIES

Please check all surgeries that apply and the date they were performed:

YEAR:		YEAR:		YEAR:	
_______	Appendectomy	_______	Adenoids	_______	Neck Injury
_______	Circumcision	_______	Dental Surgery	_______	Head Injury
_______	Hernia	_______	Tubes in Ears	_______	Broken Bones
_______	Tonsils	_______	Back Injury	_______	Other _______________

FAMILY MEDICAL HISTORY

Please check any major illness in your family and list who it pertains to (mother, father, brother, sister):

- ☐ Tuberculosis ______________________________
- ☐ Emphysema ______________________________
- ☐ Heart Disease ______________________________
- ☐ High Blood Pressure ______________________________
- ☐ Osteoporosis ______________________________
- ☐ Diabetes Mellitus ______________________________
- ☐ Thyroid Disease ______________________________
- ☐ Anemia ______________________________
- ☐ Hemophilia ______________________________
- ☐ Kidney Disease ______________________________
- ☐ Epilepsy ______________________________
- ☐ Neurological Disease ______________________________
- ☐ Liver Disease ______________________________
- ☐ Breast Cancer ______________________________
- ☐ Ovarian Cancer ______________________________
- ☐ Colon Cancer ______________________________
- ☐ Prostate Cancer ______________________________
- ☐ Other ____________ ______________________________

SOCIAL HISTORY

Plese write the information that applies to you:

School Name: ____ Grade: ____________________

Favorite Foods: ____

Food Allergies: ____

Special Diet: ____